

## **NEBRASKA'S TITLE V 5-YEAR NEEDS ASSESSMENT**

The Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), provides detailed guidance for states receiving Title V MCH Block Grant funds. Nebraska Health and Human Services Regulation and Licensure (NHHS, R&L) is the recipient of the Title V Block Grant. The Office of Family Health is responsible for administering the Block Grant. One requirement in the guidance is to prepare a statewide needs assessment every five years. The assessment shall identify the need for:

- ❖ Preventative and primary care services for pregnant women, mothers, and infants
- ❖ Preventative and primary care services for children; and
- ❖ Services for Children with Special Health Care Needs (CSHCN)

### **I. Nebraska's Needs Assessment Process**

#### **A. Data Driven Process**

Following the completion of the 2000 needs assessment, NHHS R&L's Office of Family Health has planned and invested resources into implementing an enhanced data driven process. In the past five years the Office has built capacity to identify/gather, analyze and present data relevant to the maternal and child health (MCH) and children with special health care needs (CSHCN) populations. Since 2000, the Office has established the MCH Epidemiology Unit, which staffs the State Systems Development Initiative, Child Death Review Team, and the Pregnancy Risk Assessment Monitoring System together with data management for Title V needs assessment. In addition the Office hosted two HRSA Graduate Student Internship Program (GSIP) interns whose focus was to strengthen the data capacity in preparation for the 2005 Needs Assessment.

The data process began in 2003 with a comprehensive literature review by the first intern, with recommendations on health status indicators relevant to Nebraska's MCH/CSHCN populations. Following up on this work staff assembled a database of approximately 425 indicators addressing the states target populations (women 20-44, infants 0-1 children 1-9, and youth 10-19). This was done with the assistance of the second GSIP intern during 2004. Data was collected in the fall of 2004, in the following forms, when available:

- 1) Data from 1995-current (in most cases 2003);
- 2) Data by race/ethnicity;
- 3) National rates
- 4) Healthy People 2010 objectives

Once the data was assembled it was tested for statistical significance. Indicators showing strong significance were then graphed with narrative. These indicators were then used by the Needs Assessment Committee (NAC) to assess the population, then identify and prioritize needs.

## **B. Needs Assessment Committee for MCH Populations**

The Office of Family Health first assembled the Needs Assessment Committee (NAC) in the summer of 2002. The NAC participated in reviewing the recommended indicators for MCH/CSHCN indicators in 2003. A key role of the group was to then review the data, identify the problems and needs of the MCH population and then prioritize among the identified problems.

Early in 2004, The Office of Family Health reviewed the input of the NAC and the data collected and analyzed to date. Staff determined that technical assistance was needed in two areas:

- 1) A process responsive to and suitable for assessing needs of CSHCN and their families; and
- 2) A process for prioritization

Technical assistance regarding CSHCN was sought and received from Dr. Beverly Mulvihill (see the following section for details on her consultation). The Office of Family Health received consultation on and facilitation of a prioritization process from Judith Belfiori, MPH, MA and Geraldine Oliva, M.D., MPH with the Family Health Outcomes Project (FHOP) located at The University of California, San Francisco.

Ms. Belfiori and Dr. Oliva helped develop a formal facilitated process. Their process was designed to minimize the potential for the individual interests to override the shared interests of the larger group. It was used to prioritize needs of the MCH population (women, infants, children and youth). The consultants:

- 1) Lead the group through a structured group process;
- 2) Maintained the group's focus;
- 3) Assured that all members had equal opportunity for input and
- 4) Provided a method for documentation of the process.

The systematic process used by the consultants consisted of criteria setting, data presentation, identification of problems, and setting priorities among the identified problems. This process had been used successfully for work with large planning groups with a diverse membership, such as Nebraska's. The process was adapted from a method included in the University of North Carolina, Program Planning and Monitoring Self-Instructional Manual, "Assessment of Health Status Problems" and described in the University of California at San Francisco Family Health Outcome Project (FHOP) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs".

There were two meetings of the Needs Assessment Committee (NAC) for the purpose of setting priorities among identified needs. Prior to the first meeting the consultants interviewed seven key stakeholders, recommended by staff, to assess the level of engagement of the group, obtain feedback on their experience with any previous Title V assessments and elicit concerns about or suggestions for the current process. In addition to the two large NAC meetings, small workgroups specific to particular populations

(Infant, Children, Youth, and Woman) met in the time period between the two large group meetings to review data, and then identify and prioritize problems. Each workgroup produced five problems or needs and recommended them to the larger group (NAC) for consideration in the overall prioritization process. CSHCN followed a parallel process described later in this document.

	Steps in the NAC Process for Prioritizing Needs
1.	Present overall objectives and the recommended process for prioritization to NAC
2.	NAC selects criteria for the ranking of problems
3.	NAC develops criteria rating scales
4.	NAC determines weights for each criterion
5.	NAC reviews preliminary draft of data
6.	Convene workgroups, assign tasks and provide orientation and experience in applying criteria
7.	Workgroups review all the available data for their population group and identify problems/needs
8.	Presentation of identified problems and data summary from all workgroups to the larger planning group
9.	Agree on the final problem list to be prioritized
10.	Use weighted criteria to score problems
11.	Sum participant's scores / rank problems
12.	Discuss and confirm results

Steps 1 through 6 were completed during the NAC meeting on November 18, 2004. Small workgroups met in the period between November 18, 2004 and March 16, 2005 to complete Step 7. Steps 8 through 12 were completed during a second NAC meeting on March 16, 2005.

The steps are described in more detail as follows:

#### 1. Set the Objectives and Process of Prioritization

The process began with an overview of the priority setting process and an introduction of the objectives of the process. Participants were encouraged to ask questions. The importance of the member's participation and their efforts to take a global overview, objective approach--setting aside their special interests--was emphasized.

## 2. Select Prioritization Criteria

The group developed criteria to prioritize health and health care access problems/needs of Nebraska's MCH population. These criteria were used to assess health problems/needs, such that the group could determine if a given problem was more or less important compared to other problems. The discussion of the criteria was important and it stimulated critical thinking. Selection of criteria before discussion of the specific health problems was equally as important.

The consultants presented a list of possible criteria used by other groups to illustrate how criteria are defined. The group added, changed and removed criteria. The group was given time to discuss the proposed criteria, to assure each member has a common understanding of each criterion, and to reach consensus on the criteria it will use. The NAC decided upon six criteria.

## 3. Develop Criteria Rating Scales

Once the group agreed on the criteria, a rating scale particular to each criterion was developed. A rating scale is a way to assure that each participant is using the same, agreed upon definitions and rating system. The rating system was used to capture the degree to which a problem meets a criterion. It can be a 2, 3, 4, or 5-point scale. The consultants recommended and the NAC adopted a 5-point scale. After the meeting the consultants developed the rest of the scale and provided it to each workgroup for use at future meetings. This was acceptable to the NAC.

## 4. Determine Weights for Each Criterion

Not all of the criteria developed are of equal importance. This method involves the process of weighting each criterion using a points system. For example, using a scale of 1 to 3, a criterion is given a weight of "1" if it is considered important but not as important as other criteria, "2" if more important than some criteria but not as important as other criteria and a "3" if of very great importance. With the guidance of the consultants the weighted score for each criterion was agreed upon and determined by group consensus. The final set follows this discussion.

## 5. Review of Preliminary Data

For the initial large group meeting staff and consultants lead the group in a review of draft data on selected indicators. The group received information on how to identify specific problems and how to take into account the needs of specific subpopulations such as race or ethnic groups, cross cutting issues such as access to care, and systems issues such as the need for a medical home.

## 6. Convene workgroups, assign tasks and provide orientation and experience in applying criteria

Staff provided direction and facilitated the organization of the workgroups. The workgroups were Women, Infants, Children, and Youth. The consultants provided orientation and technical assistance to staff in the process of detailed data review, using the preliminary data and the prioritization criteria. This was meant to assist NAC members in gaining experience in using the criteria to assess data.

7. Workgroups review all the available data for their population group and identify problems/needs

The workgroups met following the November 2004 NAC meeting to review all the available data for and to identify the problems/needs of its population group. At each meeting, the staff presented an overview and summary of available data, described the data collection and analysis process, and presentation format.

Workgroups were asked to select five (5) needs to propose to the larger group. They determined the list of needs to submit to the larger NAC by utilizing the agreed upon criteria and prioritization tool.

8. Presentation of identified problems and data summary from all workgroups to the larger planning group

With the assistance of staff each work group produced fact sheets that articulated the problem/need and addressed the criteria. The fact sheets were presented to the NAC along with a verbal presentation.

9. Agree on the final problem list to be prioritized

After review of the fact sheets and data analysis, full NAC, by consensus, combined problems, and refined some of the problem statements (e.g., specify a specific population experiencing the problem). Some suggestions were prepared by the facilitators and MCH staff in advance of the meeting to help guide the group if needed. Twenty problems/needs were collapsed into twelve problem statements.

10. Use Weighted Criteria to Score Problems

Group members individually use the weighted prioritization criteria to score each of the remaining 12 problems. The consultants provided a copy of the problem prioritization matrix designed to use the weighted criteria with the problems imbedded. The consultants instructed participants in the use of this tool and ensured that every participant used the scoring system accurately. Each participant then scored each of the problems. An example of the scoring tool follows this discussion.

11. Sum Participant's Scores / Rank Problems

The results of the individual scoring of each problem were entered in a summary table that showed the sum total of the weighted individual scores and the rank order of each

problem. The total scores were ranked from the highest, which is priority 1, to the lowest, which were 12. The summary was presented to the group.

## 12. Discuss and Confirm Ranked Results

The ranked list of prioritized problems was then discussed among and accepted by the group. Questions and disagreements were discussed and resolution achieved prior to accepting the ranking.

### **Criteria Developed and Used by the NAC for Prioritizing Identified Problems/Needs**

The following is a summary of the work done by the NAC in reaching consensus on a set of criteria for use in setting priorities among the problems/needs identified by its workgroups. The six criterion had a ranking of 1 through 5 and were weighted by the NAC using a scale of 1 to 3 with 3 being the most important.

#### **Criterion 1: An Effective Intervention is Available**

**Expanded Definition/Concepts included:** This means that there is a good chance that the strategies used to intervene in the identified problem will result in an improvement in outcomes. The intervention strategies are shown in research literature, by experts or by local experience to be effective or promising. This criterion is intended to incorporate two concepts: 1) the importance of the existence of a promising or proven intervention strategy and 2) the concept of “strategic efficacy”. Strategic efficacy means that an intervention aimed at the identified problem will also result in positive effects on a wider array of problems, resulting in “more bang for the buck”.

**Criterion Weight:** 3

#### **Rating Scale:**

- 1= No known intervention available
- 2= Promising intervention with limited impact (not effecting a wider array of problems)
- 3= Proven intervention with limited impact
- 4= Promising intervention with broad impact
- 5= Proven intervention with broad impact

#### **Criterion 2: Disproportionate Effects Among Subgroups of the Population**

**Expanded Definition/Concepts included:** This means that one or more population subgroups as defined by race, ethnicity, income, insurance status, gender or geography have *statistically* significantly worse indicator values of illness or condition when compared to another group. This criterion is meant to include the concept of “social justice” When using this criterion in ranking a problem that is a composite of multiple indicators the rater can use any one of the indicators for which data exists to evaluate whether the problem meets the criterion and to what degree.

**Criterion Weight:** 2

**Revised Rating Scale:**

- 1= No group is disproportionately affected by the problem
- 2= It appears that one or more groups is disproportionately affected by the problem, but differences are not statistically significant
- 3= Statistically significant differences exist in one group and the disadvantaged group is at least 1.25 to 1.75 times more likely to have a poor outcome
- 4= Statistically significant differences exist in more than one group
- 5= Statistically significant differences exist in one or more groups and at least one of the disadvantaged groups is greater than 1.75 times more likely to have a poor outcome

**Criterion 3: Problem is Worse than the Benchmark or Increasing**

**Expanded Definition/Concepts included:** A benchmark is defined as the standard by which something can be measured or judged. Getting worse means that the problem identified is statistically significantly worse in Nebraska when compared to a benchmark such as the U.S. average value or the Healthy People 2010 objective. It also incorporates the concept that even if there is not a significant difference when compared to a benchmark the problem has been getting significantly worse over time, i.e., the trend is in the wrong direction.

**Criterion Weight: 2**

**Rating Scale:**

- 1= No significant difference between Nebraska's indicator value and the benchmark and no negative trend
- 2= Nebraska's indicator value is better than the benchmark level but getting worse over time
- 3= Nebraska's indicator value is worse but significantly improving over time
- 4= Nebraska's indicator value is worse and not changing significantly over time
- 5= Nebraska's indicator value is significantly worse and getting worse over time

**Criterion 4: Severity of Consequences**

**Expanded Definition/Concepts included:** This means that the problem identified could result in severe disability or death. The intent of the group is to incorporate the concept of "potential for re-emergence". This means that even though some health indicators may have improved due to effective interventions, these interventions must be sustained to avoid severe negative outcomes. An example of this would be the importance of sustaining an effective immunization program to avoid the reemergence of vaccine-preventable diseases.

**Criterion Weight: 3**

**Rating Scale:**

- 1= Problem is not life threatening or disabling to individuals or community
- 2= Problem is not life threatening but is sometimes disabling
- 3= Problem can be moderately life threatening or disabling

- 4= Problem can be moderately life threatening but there is a strong likelihood of disability
- 5= Problem has a high likelihood of death and disability

**Criterion 5:** There is Impetus for Change

**Expanded Definition/Concepts included:** This means that there is an environment that would be supportive of choosing a problem as a priority and of directing resources towards improving outcomes associated with this problem. It incorporates the concepts of the importance of the issue to community members or policy makers as well as the potential for communicating the importance of the problem to these groups.

**Criterion Weight:** 1

**Rating Scale:**

- 1= Problem not perceived as important to community or policy makers
- 2= Problem not perceived as important but severity can be conveyed to these groups
- 3= Recognized as a problem by community but no support from policy makers
- 4= Recognized as a problem by both community and policy makers
- 5= Strong across the board support to direct resources to intervene

**Criterion 6:** Large Number of People Affected

**Expanded Definition/Concepts included:** This criterion considers the absolute number of people affected. It includes the concept that targeting a problem affecting a large number of individuals could have a greater impact on the health of the community than one affecting a relatively small number of people. This criterion is intended to provide a balance for a situation in which a few occurrences of a particular problem in a small group can result in a high rate but in reality the condition may only effect a few individuals in the community, e.g., a geographic area with a very small population and few births that has one teenage pregnancy will result in a high teen pregnancy rate for that geographic area.

**Criterion Weight:** 2

**Rating Scale:**

- 1= Few individuals affected
- 2= Moderate number of individuals affected in particular subgroups
- 3= Moderate number of individuals affected across the entire population
- 4= Large number of individuals affected in particular subgroups
- 5= Large number of individuals affected across the entire population

### **Problem Prioritization Tool**

CRITERION #1: AN EFFECTIVE INTERVENTION AVAILABLE				CRITERION #4: SEVERITY OF CONSEQUENCES			
CRITERION #2: DISPROPORTIONATE EFFECTS AMONG SUBGROUPS OF THE POPULATION				CRITERION #5: THERE IS IMPETUS FOR CHANGE			
CRITERION #3: PROBLEM IS WORSE THAN THE BENCHMARK OR INCREASING				CRITERION #6: LARGE NUMBER OF PEOPLE AFFECTED			
Problem	In the line below each criterion number (e.g. C1), record assigned weight as decided by the group. Then, for each problem, score each criterion (use agreed upon rating scale) and multiply the score by the assigned weight. Add weighted criterion scores to obtain Total Score for Problem.						Total Score For Problem
	C1	C2	C3	C4	C5	C6	
		3	2	2	3	1	2
1.							
2.							
3.							
4.							
5.							
6.							
7							
8.							
9.							
10.							

### **C. CSHCN Workgroup**

The creation of a separate CSHCN Work Group was a key recommendation of Dr. Beverly A. Mulvihill, who served as a consultant to the Department in October 2004. She reviewed past and current needs assessment efforts and interviewed key stakeholders in the CSHCN needs assessment process. In her report to the Department, Dr. Mulvihill noted the following challenges in a needs assessment for the CSHCN population:

- Limited quantitative data
- Limited qualitative data
- Limited integration of data
- No consensus definition of the target population
- No consensus on indicators and expected outcomes
- Limited group of stakeholders

Dr. Mulvihill observed that in the last needs assessment CSHCN had been examined along side the needs of all children in Nebraska. There was no separate process for the CSHCN population. She wrote, "Certainly all families need high quality health care that is affordable and accessible regardless of geographic, financial or other potential barriers. On the other hand, children with disabilities and chronic illnesses and other special needs may encounter unique challenges in giving their health needs met within a variety of setting such as the community or school environment." She recommended a separate

needs assessment process with an expanded Work Group membership. She also recommended adoption of the Maternal and Child Health Bureau's six national core outcomes to guide the identification of performance indicators. Dr. Mulvihill concluded her technical assistance by presenting recommendations to the NAC. Her recommendations were approved and incorporated in to Nebraska's process.

The Office of Family Health, in cooperation with the Office of Aging and Disability Services, contracted with Dr. Christine M. Reed from the School of Public Administration University of Nebraska at Omaha to facilitate a separate work group to identify three priority needs for Children with Special Health Care Needs. The scope of services included the following:

- Identify and invite family and professional partners to participate in the CSHCN Needs Assessment Work Group;
- Identify existing databases, both those internal to the Department and those available from other agencies and organizations, working with the Department to collect and assemble;
- Analyze existing data bases and prepare summary reports;
- Facilitate meetings of the CSHCN Work Group to review reports generated by existing databases, recommend additional sources of information, and identify priority needs;
- Circulate draft needs assessment document to members of the Work Group for comments, edit and submit final CSHCN needs assessment document to Department.

Selection Criteria: Selection criteria used by the CSHCN Work Group were different from the prioritization criteria developed by the Needs Assessment Committee for application to populations of women, infants, children and adolescents. There were three major reasons for this difference:

- 1) The databases available for assessment of CSHCN were first-time sources, and so the Work Group was limited in its analysis to establishing performance base-lines as opposed to trend-lines;
- 2) The number of CSHCN in Nebraska is small and their needs are unique compared to the population of all children and adolescents, and so certain criteria applicable to the large population were not appropriate for assessment of needs for CSHCN; and
- 3) The conceptual framework for the CSHCN needs assessment was the six core outcomes of the MCHB National Agenda, and so the emphasis was on performance indicators for the system of health care as opposed to health conditions and/or health outcomes.

The selection criteria used by the CSHCN Work Group were the following:

- **Importance of the Performance Indicators.** Are the performance indicators for one of the six core outcomes significantly worse than are the performance

indicators on the other outcomes? Are the performance indicators for one of the six core outcomes significantly worse for one sub-group of CSHCN than for others? Does the performance indicator suggest a significant hardship for families of CSHCN? Do the performance indicators from more than one database point to the same need?

- **Potential for Improved Performance:** Is there a potential for improvement in family-centered community-based care for CSHCN? Is there a promising intervention strategy for the identified need either at the state and/or the community levels? Is the need acknowledged as important for the identified by community members and/or policy makers OR is there a potential for communicating the importance of the issue/need to these groups?

Each member of the CSHCN Work Group scored the list of identified needs on two scales: How important? (5=most critical to 1=least critical) and Potential for Improved Performance? (5= excellent potential to 1=poor potential) At the second meeting, they scored the initial composite list of 12 needs but no clear consensus emerged from the scoring process. At the second meeting, they scored the shorter, revised and arrived at a consensus on the top three priority needs for CSHCN. At both meetings Dr. Reed transposed the scores to two-dimensional matrices in order to provide a visual display of how the scores clustered along the importance and potential for improved performance scales. She created a separate matrix for each need. An individual score for each need was shown on the two-dimensional matrix as an "X" and when there was a cluster of scores in the upper right quadrant of a particular matrix it indicated consensus among members of the group that the need was high on importance and high on potential for improved performance

Databases: The CSHCN needs assessment used the six core outcomes as the conceptual framework. Performance indicators organized under each of the six core outcomes were derived from three major sources:

- 1) the National Survey of Children with Special Health Care Needs;
- 2) the Nebraska CONNECT system; and
- 3) summaries of reports from the Early Development Network Region Planning Teams, which identified gaps and barriers to performance.

The Data Resource Center for Child and Adolescent Health sponsored by the Child and Adolescent Health Measurement Initiative (CAHMI) provided statistical analyses of survey results from the National Survey of CSHCN. Their web site allows users to search by specific question on the survey instrument, to view composite scores for each of the six core outcomes, to analyze performance by sub-group of CSHCN (e.g. racial and ethnic sub-groups) and to compare national results to state and regional results. Since the National Survey was organized around the six core outcomes, data from different parts of the survey were converted directly to performance indicators for each core outcome.

Mr. Roger Hillman, Acting Unit Manager for the Medically Handicapped Children's Program, provided data summaries from the CONNECT system. These data summaries reflected information posted to the system by MHCP services coordinators and reflected not only the numbers of children served by Title V but also their primary sources of health coverage and needs identified by the services coordinators but unmet by agencies and programs outside of Title V CSHCN programs (i.e., the Medically Handicapped Children's Program and/or the Disabled Children's Program). Data summaries from the CONNECT system and from The Early Development Network Gaps and Barriers Committee Report were converted to performance indicators and added to the list from the National Survey.

Meeting 1: The first meeting took place at three separate locations on January 27 (in Lincoln) January 28 (in Omaha) and March 1, 2005 (in Kearney.) Dr. Reed presented power point slides, which included the following:

- History of the Title V CSHCN Program and the MCHB National Agenda
- Summary of the six core outcomes in the MCHB National Agenda
- Definitions of CSHCN as they have evolved over time
- CSHCN Screener Definition of CSHCN used in the National Survey of Children with Special Health Care Needs
- Schematic of Title V CSHCN Programs in Nebraska and prevalence of children in those programs, as well as Medicaid.
- Conceptual framework for the CSHCN needs assessment using the six core outcomes and using performance indicators under each core outcome to identify priority needs
- Initial performance indicators for each core outcome using the National Survey of CSHCN and the CONNECT system.

There was a general discussion following these slides about other performance indicators that might be available for Dr. Reed to collect before the second meeting. Dr. Reed sent out a revised version of the power point slides (see Attachment A) by e-mail to Work Group members on February 21 which included additional performance indicators, an explanation of the criteria to be used in selecting priority needs and a request to each member to send Dr. Reed three to five issues/needs from which she would compile a master list for review and discussion at the second meeting.

Meeting 2: The second meeting took place in videoconference format on March 1, 2005. Dr. Reed presented the combined list of 12 needs from Work Group members, facilitated a discussion about each of those needs and asked members to score each need. Members faxed their scores to Dr. Reed, who was facilitating from the Lincoln site, and she compiled those scores for the Work Group to see before the meeting adjourned. Since there was no clear consensus on three priority needs, a third meeting was scheduled for March 24, 2005.

Meeting 3: The third meeting took place in videoconference format on March 24, 2005. Dr. Reed presented a revised list of needs in which four needs were dropped, because

there was a weak consensus within the group based on the selection criteria. Ms. Julie Miller also moved to drop the need for expanded newborn genetic screening, because that initiative was already in the initial stages of implementation. The group agreed to drop the five needs, and then they scored the remaining needs. They faxed their scores to Dr. Reed, and she compiled those scores for the group to see before the meeting adjourned. A clear consensus emerged on the top three priorities for CSHCN. There was further discussion about wording changes and clarification on the priority needs and then the meeting adjourned.

## **II. Participation and Collaboration**

### **A. Participants**

An important aspect of the assessment process is the participation by stakeholders throughout the state in identifying and prioritizing among identified problems and in providing input on the development of strategies to intervene in prioritized areas. Equally as important to Nebraska is an active and engaged committee. The NAC identified bellow was a hard working dedicated group. One way to improve the committee would be to engage family/parents participation outside of the CSHCN population.

Needs Assessment Committee Members/Collaborators			
Individual	Represents	Subcommittee /Workgroup	Larger NAC
J.Anderson	Non-Profit	Infant	X
B.Cernech	Visiting Nurses	Infant	X
C.Kukuk	Local Health Department	Infant	X
L.Lowry	Tribal Public Health Nursing	Infant	X
K.Powell	Hospital	Infant	X
R.Delaney	Staff, NHHS	Infant	X
L.Langely	Tribal Nursing	Women	X
K.McFarland	DDS, NHHS	Women	X
M.Balluf	Local Health Department	Women	X
J.Rodriquez	Minority Health, NHHS	Women	X
K.Ward	Women's Health, NHHS	Women	X
J.Severe-Oforah	Staff, NHHS	Women	X
R.Weight	Non-Profit	Youth	X
S.Kadoi	Non-Profit	Youth	X
S.Roes	Hospital	Youth	X
J.Heusinkveldt	Staff, NHHS	Youth	X
L.Henningsen	Staff, NHHS	Youth	X
J.Noyd	Local Health Department	Children	X
J.Rother	Local Health Department	Children	X
K.Nordby	Local Health Department	Children	X
J.Beitz	Injury Prevention, NHHS	Children	X

P.Trouba	WIC, NHHS	Children	X
S.Huffman	Staff, NHHS	Children	X
N.Shank	Non-Profit	CSHCN	
G.B.Schafer	MD- Pediatrics	CSHCN	
M.Smith	Family Coordinator	CSHCN	X
N.Baker	Non-Profit, Family Partner	CSHCN	X
J.Stec	Hospital	CSHCN	X
J.Miller	Newborn Screening, Genetics, NHHS	CSHCN	X
M.Gordon	Developmental Disability Council, NHHS	CSHCN	X
J.Hoffman	Newborn Hearing, NHHS	CSHCN	X
N.Grant Sikyta	Tribal Health, NHHS, Family Member	CSHCN	X
J.Garvin MD	Staff, NHHS	CSHCN	
M.J.Iwan	Aging and Disability, NHHS	CSHCN	X
D.Herbel	CSHCN Clinic	CSHCN	
K.Authier	Non-Profit	CSHCN	
D.Weimer	Family Member	CSHCN	
T.Wiese	Family Member	CSHCN	
P.Davis	Family Member	CSHCN	
K.Meyer	Facilitator, Therapist	CSHCN	X
C.Reed	Facilitator, Family Member	CSHCN	X
L.Marsh	Hospital		X
B.Semm	Non-Profit		X
F.Peak	Teaching Hospital		X
S.Forkner	Local Health Department		X
J.Fralin	Community Action		X
C.Becker	Birth Defect Registry, NHHS		X
A.Muese-Thomalla	Reproductive Health, NHHS		X
P.Eurek	Staff, NHHS	ALL	X

## B. NAC Participant Process Evaluation

The following is a summation of evaluations submitted by sixteen of the NAC/Workgroup members. The first section is regarding the two NAC meetings (November 18, 2004 and March 16, 2005), the second section refers to the small work groups, and the third related to the process overall.

### NAC

**(9/16) 56%** Attended the meeting on November 18, 2004

**(11/16) 69%** Attended the meeting on March 16, 2005

Rating on a scale of 1 (poor) to 5 (excellent)

**4.0** The time of the meetings

**4.2** The presentation of information about the needs assessment process

- 4.27 The facilitation
- 4.27 The materials you received prior to the meetings
- 4.27 The materials in your meeting packets
- 3.93 Explanation/understanding of data
- 4.2 Development/use of criteria to guide the process
- 3.87 The use of the criteria to organize and present workgroup data
- 3.67 The use of the problem prioritization tool
- 3.93 Opportunities for stakeholder input
- 4.27 Fairness of process

**80%** I learned something...

### Positive Feedback

- I learned a lot about public health vs. behavioral health. I also learned about Title V in general
- Good exercise to work with a committed group to analyze data and develop problem statements and priority areas
- The evaluation tool worked very well in helping the group narrow down the criteria to the allowable choices. I believe it actually brought to the top the critical issues
- Much greater breadth of information on MCH and Title V services in Nebraska
- There are some very dedicated, intelligent individuals in the State of Nebraska who get it.
- I'd never done such a complete a process before
- Developing further, my skills in synthesizing data into problem statements
- Some people with strong feelings can influence the final result but the group method seemed to assist with this undue influence
- Too numerous to list ...mostly re: the data collected in the summaries

### Constructive Feedback

- That we have some data, but sometimes it is difficult to know what is really significant. You need the context for the data
- I liked the prioritization tool concept, however, in application, if you have an issue (like breastfeeding) that is really important but is improving or doesn't cause "death or severe injury" if its missing it's really hard to get it to score high enough to ever be a priority. I see this as a weakness of using this tool.

### Work Group

Respondents represented: 3/5 infant, 2/5 children, 2/4 youth, 3/5 women, and 5/11 CSHCN

### Rating on a scale of 1 (poor) to 5 (excellent)

- 3.87 The time of the meetings
- 4.2 The presentation of information about the needs assessment process
- 4.53 The facilitation
- 4.33 The materials you received prior to the meetings
- 4.00 The materials in your meeting packets
- 3.80 Explanation/understanding of data
- 4.2 Development/use of criteria to guide the process

- 4.07 The use of the criteria to organize and present workgroup data
- 4.00 The use of the problem prioritization tool
- 4.07 Opportunities for stakeholder input
- 4.40 Fairness of process

**73%** I learned something...

#### Positive Feedback

- I learned a great deal about data that's out there and, just as important, the data that is not out there
- I liked the way the problem statements and justifications were structured; I may use a variation in the future
- There are significant forces at work in the State trying to effectuate great change for the benefit of children with special health care needs
- That a process is available and that priority areas are not just chosen by the agencies/staff members special interests
- Using a Problem Prioritization Tool to prioritize identified problem statements

#### Constructive Feedback

- The group is really dependent on the knowledge of the participants to give meaning to the data
- We need to work harder to protect women and children
- Prioritization tool was different for CSHCN. I think perhaps a bit less objective than the process used for the other groups. If we had better data for CSHCN population, I would recommend using some – perhaps 3 of the criteria used from the other groups.

#### Overall Evaluation

- 4.19 Overall Rating
- 4.44 Commitment to supporting final 10 priorities

#### Positive Feedback

- Thanks for all the hard work!
- I think this is one of the best processes I have been through for the State. In the end. I feel we generated a fair list of priority areas that was completed under a democratic process. Thanks for giving me the opportunity!
- No, this was the best, most objective (as possible) process we've had for the needs assessment, since I've been here (10 years). I think you all deserve kudos for some really great work!

#### Constructive Feedback

- Start process earlier
- Continue to involve and encourage parental involvement

- I thought the process from the few meetings I attended went very well. The only concern is that when data was not available, it was hard to score trends, comparison to baseline. I am not sure how to fix this. If data is not available is it because nothing is being done so there is no data, which would indicate a great need or is it because it is not a major problem so no one is keeping the data.
- If you are going to continue to give infrastructure grants you need a process to include infrastructure priorities
- I hope breastfeeding fits in somewhere

### **III. Assessing the Needs**

The needs of Nebraska's MCH/CSHCN populations were predominantly assessed by small work groups. There were five workgroups total representing women, infants, children, youth and CSHCN. Each group was charged with investigating the status of the MCH population paying special attention to racial/ethnic populations (Form 20 and 21 of Title V Block Grant Application). Generally each group reviewed data on their population and sought to articulate the greatest need based on predetermined criteria. The analyzed data that was utilized is attached to this needs assessment. See the previous section for details of the workgroup process.

The following is a description of what each work group assessed to be the greatest needs. Each group was limited to five problems/needs and produced fact sheets that documented their assessment of the need. Each topical fact sheet identifies a problem statement and then addresses the six criteria described in the section titled: Needs Assessment Committee for MCH Populations. Finally, as described earlier the CSHCN population followed a modified approach so their information below is presented differently.

#### **A. Women (ages 20-44)**

The women's work group was provided with data on 120 indicators addressing the following health topics:

- 1) Anemia
- 2) Alcohol and Tobacco Use
- 3) Asthma
- 4) Cancer
- 5) Cardiovascular Disease and Risk Factors
- 6) Communicable Disease
- 7) Health Care Access
- 8) Injuries
- 9) Mental Health
- 10) Medicaid (Pregnancy)
- 11) Mortality
- 12) Oral Health
- 13) Pregnancy -Prenatal Care
- 14) Pregnancy -Delivery
- 15) Pregnancy- Weight gain

- 16) Preventative Health
- 17) Reproductive Health

Based on the assessment of the health of Nebraska's women the following five needs were presented to the NAC:

- 1) Breast Cancer
- 2) Tobacco Use
- 3) Overweight
- 4) Prenatal Care
- 5) STD's

The full assessment of these five topics in the form of fact sheets can be found at the end of this document; pages 38-47.

#### **B. Infants (age 0-1)**

The infant's work group was provided with data on 120 indicators addressing the following health topics:

- 1) Access to Health Care
- 2) Alcohol, Tobacco, and Other Drug Use (Maternal)
- 3) Anemia
- 4) Births
- 5) Birth Conditions
- 6) Birth Conditions - Birth Defects
- 7) Birth Conditions - Birth Weight
- 8) Birth Conditions - Prematurity
- 9) Breastfeeding
- 10) Child Abuse and Neglect
- 11) EPSDT (Medicaid)
- 12) FAS and Drug Dependency
- 13) Growth
- 14) Immunizations
- 15) Lead Screening
- 16) Mortality
- 17) Mortality, Intentional Injuries
- 18) Non-Fatal Injury, Unintentional Injuries
- 19) Newborn Screening
- 20) Oral Health
- 21) Prenatal Care
- 22) Preventative Health Practices
- 23) STD's

Based on the assessment of the health of Nebraska's infants the following five needs were presented to the NAC:

- 1) Preterm and Low Birthweight births
- 2) Smoking during pregnancy and post-partum
- 3) Infant mortality
- 4) Adolescent birth outcomes
- 5) Breastfeeding initiation and duration

The full assessment of these five topics in the form of fact sheets can be found at the end of this document; pages 48-54.

### **C. Children (ages 1-9)**

The children's work group was provided with data on 60 indicators addressing the following health topics:

- 1) Access to Health Care
- 2) Asthma
- 3) Child Abuse and Neglect
- 4) Immunizations
- 5) Lead
- 6) Mortality
- 7) Medicaid (EPSDT, SCHIP)
- 8) Nutritional Status
- 9) Oral Health
- 10) Tobacco Exposure
- 11) Intentional Injuries, Non-fatal
- 12) Unintentional Injuries, Non-fatal

Based on the assessment of the health of Nebraska's children the following five needs were presented to the NAC:

- 1) Overweight
- 2) Unintentional injuries
- 3) Abuse/neglect/intentional injuries
- 4) Secondhand smoke
- 5) Oral Health

The full assessment of these five topics in the form of fact sheets can be found at the end of this document; pages 55-65.

### **D. Youth (age 10-19)**

The youth's work group was provided with data on 128 indicators addressing the following Health topics:

- 1) Access to Health Care
- 2) Asthma
- 3) Birth Outcomes-Mortality

- 4) Child Abuse and Neglect
- 5) Communicable Disease
- 6) Immunizations
- 7) Injuries, Intentional
- 8) Injuries, Unintentional
- 9) Mental Health
- 10) Mortality
- 11) Nutritional Status
- 12) Oral Health
- 13) Reproductive Health
- 14) Risk Behaviors
- 15) Substance Use and Exposure

Based on the assessment of the health of Nebraska's youth the following five needs were presented to the NAC:

- 1) Nutritional and physical activity
- 2) Intentional injuries
- 3) Tobacco
- 4) Alcohol
- 5) Mental health

The assessment of these five topics in the form of fact sheets can be found at the end of this document; pages 66-76.

#### **E. CSHCN**

The workgroup looked at both quantitative and qualitative data for the national Six Core Outcomes:

- 1) All children will be screened early and continuously for special health care needs;
- 2) Families of CSHCN will participate in decision making and will be satisfied with the services they receive;
- 3) All CSHCN will receive coordinated comprehensive care in a medical home;
- 4) All CSHCN will be adequately insured for the services they need;
- 5) Services for CSHCN will be organized so families can use them easily;
- 6) All youth with special needs will receive services needed to support the transition to adulthood.

The assessment of the CSHCN core outcomes in the form of fact sheets can be found at the end of this document; pages 77-80.

From the data the group identified the following 12 needs for prioritization:

- 1) Expand the number of diseases that are part of the Newborn Screening process to include the six mandated and 30 supplemental disorders, as well as Cystic Fibrosis and Congenital Adrenal Hyperplasia;
- 2) Increase the number of newborns who receive follow-up care and assurance of financial coverage for hearing loss;
- 3) Increase cultural competence of medical and health professionals serving CSHCN and their families from diverse racial and ethnic backgrounds.
- 4) Increase the number of families who believe they have a real choice in services their CSHCN receive from medical professionals;
- 5) Increase capacity of community-based dental health practitioners to care for the unique needs of CSHCN;
- 6) Increase capacity of community-based medical home providers to detect and refer for treatment children with chronic emotional and behavioral health conditions;
- 7) Increase education for medical and social work professionals in hospital and community settings about referral sources for families with CSHCN;
- 8) Build capacity of medical homes for CSHCN by using telemedicine to improve the exchange of health information between hospitals/specialists and community-based medical home providers;
- 9) Reform insurance regulation to prevent company denials of coverage based on pre-existing conditions;
- 10) Increase Title V CSHCN capacity to serve increased numbers of children who meet medical and financial eligibility criteria but whose families have lost Medicaid coverage;
- 11) Expand existing websites to provide centralized access to comprehensive information about a variety of birth defects and complex medical conditions; and
- 12) Build Title V CSHCN capacity statewide to provide to transition medical clinics for CYSHCN 14-21 years.

#### **IV. Nebraska's MCH Capacity by Pyramid Levels**

For the 2005 Needs Assessment Nebraska chose a process that was focused on assessing and prioritizing the needs of the MCH/CSHCN populations. While, the information provided below on systems was a part of group discussions and a significant number of service related indicators were analyzed during the assessment phase, Nebraska has chosen to place more of an emphasis on addressing the system capacity for the MCH population as we begin to plan strategies and activities.

In general Title V in Nebraska has been moving towards an emphasis on population based and infrastructure building services, although direct patient care is still a need because of access issues. Title V continues to invest infrastructure dollars in order to impact services provided.

##### **A. Direct Health Care and Enabling Services**

Demographics and geography directly effect the distribution of direct health care services for the MCH population in Nebraska. A majority of the population is urban and located on the eastern portion of the state and most of the services are also located on the eastern portion of the state. Consequently, most of Nebraska is federally designated as health professional shortage areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). In 2003, over one-third (35/93) of Nebraska's counties have been designated, either in full or in part, as primary care HPSAs. These shortage areas potentially affect more than 10% of Nebraska's population. Further, 72% (67) of Nebraska's 93 counties have been designated, in full or in part, as containing MUAs or MUPs. Over 28% of the state's population live within the designated areas and are potentially affected by a shortage of health services.

In addition to the federally designated HPSA, Nebraska has more specific state-designated HPSAs. While the rate of federally designated areas has decreased (improved) since 1999 the more specialized state-designated areas have seen an increase (gotten worse) or remained the same. A high degree of shortage exists in each of the defined health specializations, including those directly related to MCH populations, particularly CSHCN. For example:

- ◆ Three-fourths of Nebraska's counties currently have a shortage of family practice physicians (69/93);
- ◆ 83% have a shortage of general surgeons (77/93);
- ◆ 91% have a shortage of internal medicine physicians (85/93);
- ◆ 94% have a shortage of psychiatrists (88/93);
- ◆ 95% have a shortage of pediatricians (88/93) and;
- ◆ 92% have a shortage of OB/GYNs (86/93).

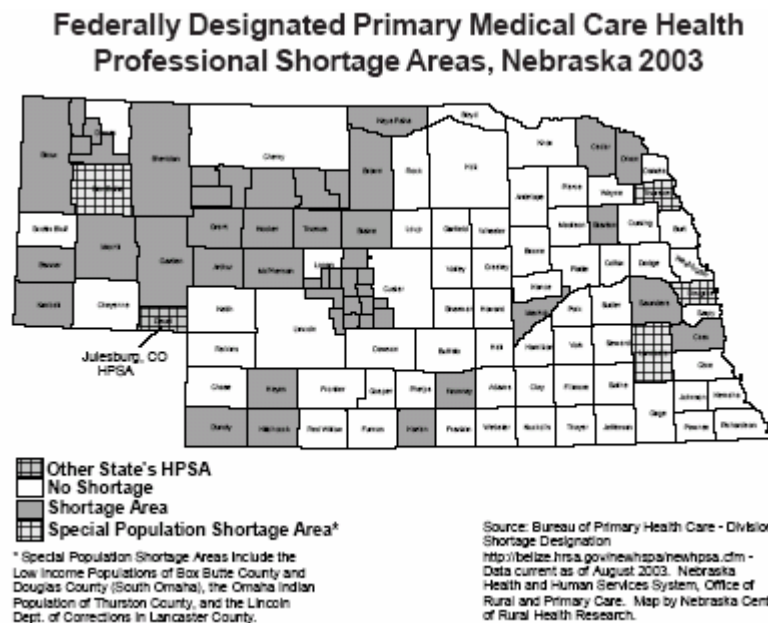
Nebraska also had federally-designated dental HPSAs. In 2003, populations within two counties in Nebraska were affected by a shortage of dental healthcare in their areas. According to the 2000 Census, about 17,374 Nebraskans live in counties containing a designated dental HPSA. The majority of the affected populations in both counties are members of the Omaha and Winnebago Indian Tribes. The Nebraska Health and Human Services System Office of Rural Health is currently analyzing and updating both geographic and Medicaid population designations. Preliminary analysis indicates that nearly 50 percent of the counties in Nebraska will qualify as federal dental HPSAs.

In 2003, the U.S. Department of Health and Human Services designated a majority of Nebraska's counties (88/93) as mental health HPSAs. One facility, the Hastings Regional Center in Adams County, has also been included. Based on 2000 census estimates, the population represented within these shortage areas (1,045,809) exceeds 61 percent of the state's total population.

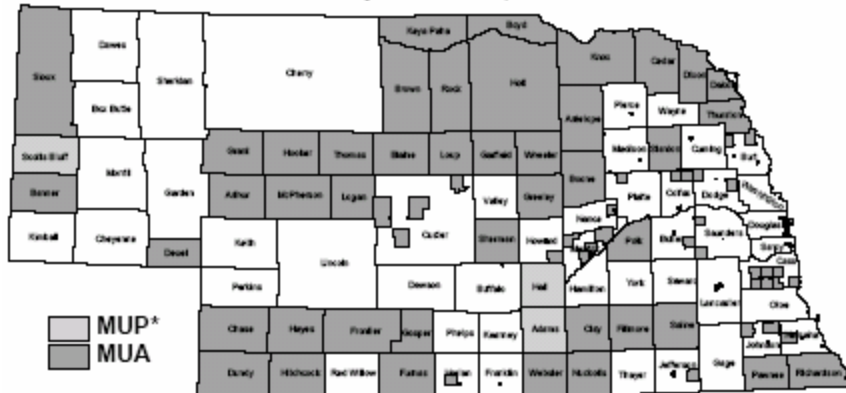
Of the 69 pediatric specialists (representing 17 different specialty areas) in Nebraska, all but five were located in Douglas County. All but one pediatric specialist practiced in the Eastern part of the state (one pediatric hematology-oncologist is located in Lincoln County and one Pediatric Surgery-Neurology is located in Buffalo County). In addition

to the 69 pediatric specialists, Nebraska has 187 pediatricians (total 256) located in 16 counties. This represents net increase in pediatrics (an increase in specialists and decrease in generalists) but a more dense distribution since 2000.

As seen in the following figures many rural areas and special population in the urban centers have an inadequate supply of primary care physicians and other health care professionals. Further, approximately 11% of Nebraskans are uninsured and many more are underinsured. The percentage of uninsured is considerably higher for racial/ethnic minorities and cultural barriers are often formidable.



## Federally Designated Medically Underserved Areas and Populations, Nebraska 2003

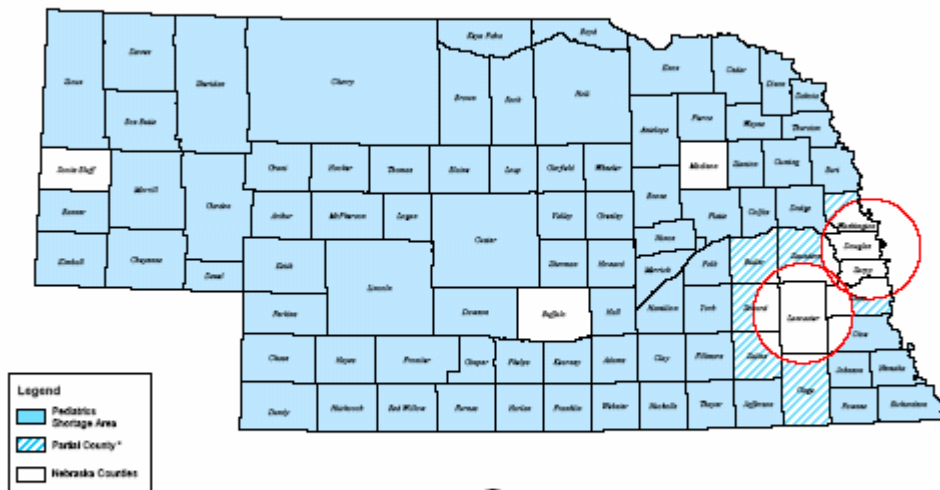


\*MUPs are Medically Underserved Populations, which include the Medicaid Population of Adams County, the Low Income/MFV Population of Hall County, and the Hispanic Population of Scotts Bluff County.  
 Source: Nebraska Health and Human Services System, Office of Rural Health, 2003.

Note: The very small shaded areas on this map, e.g., that which appears in Lancaster County, represent MUA/MUP precinct, township, or census tract boundaries. For details on these areas, see Table 4.

## State-Designated Medical Shortage Area General Pediatrics

Nebraska - 2004



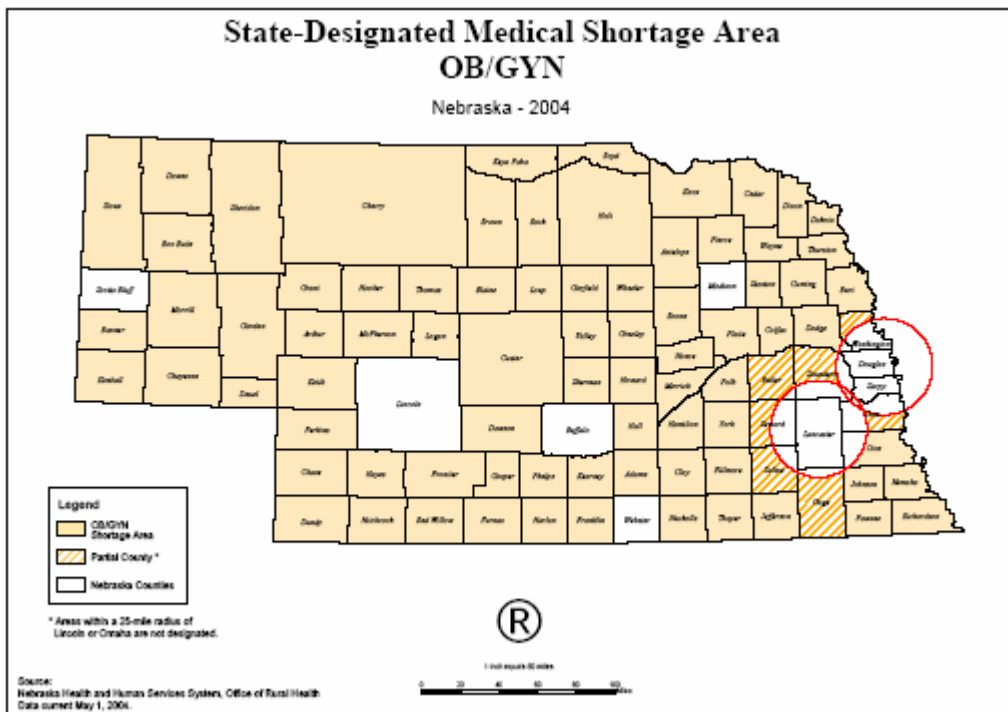
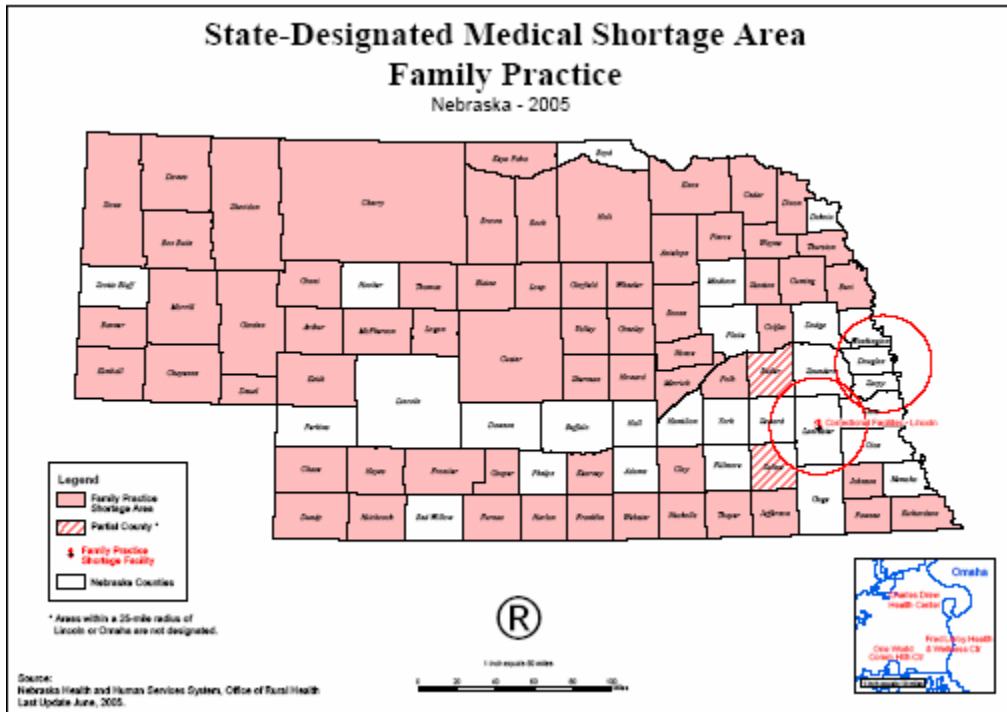
\* Areas within a 25-mile radius of Lincoln or Omaha are not designated.



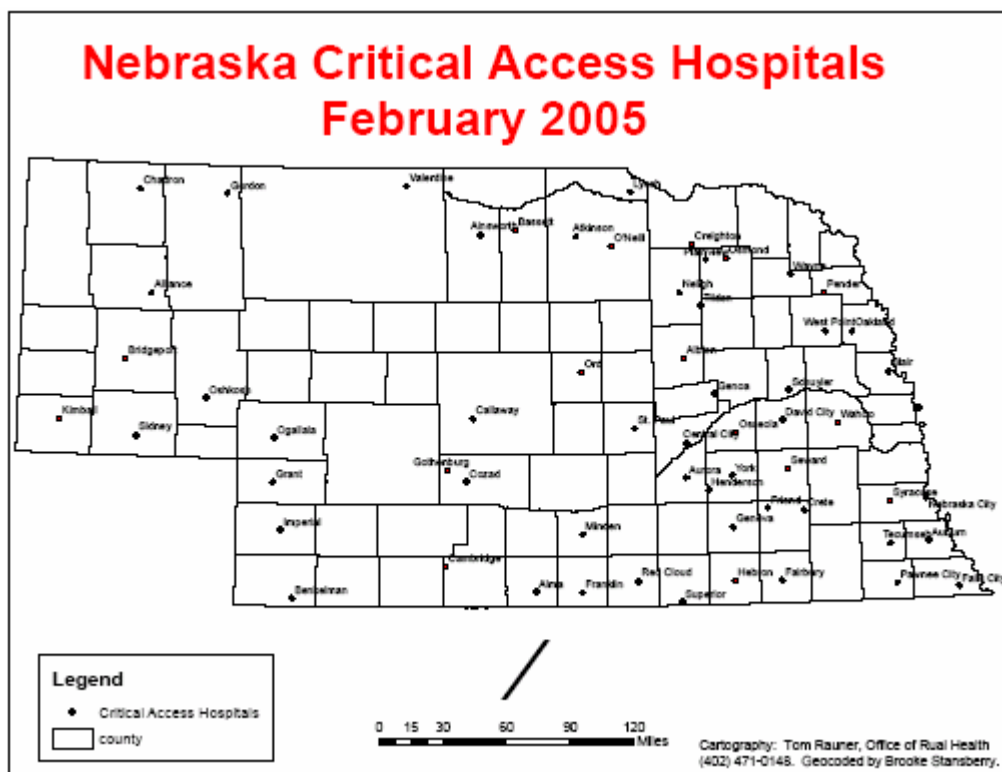
1 inch equals 40 miles



Source:  
 Nebraska Health and Human Services System, Office of Rural Health  
 Data current May 1, 2004.



Additional issues that impact Direct Health Care Services and Enabling Services are the challenges faced by Nebraska's hospitals. Due to the financial pressures of operating in rural areas, 61 Nebraska hospitals have been designated as critical access hospitals. These rural hospitals have taken on new roles in providing community based health services, including those for the MCH/CSHCN population. Critical access hospitals have implications for emergency care for MCH/CSHCN, as well as perinatal care and preventive population-based services.



To combat the rural isolation of health care providers and critical access hospitals Nebraska has invested in a telehealth network. The Nebraska Statewide Telehealth Network (NSTN) will provide the opportunity for all hospitals and public health departments to connect, providing access to consultations with medical specialists, continuing medical education, transmission of digital clinical information, bioterrorism alerts and training for homeland security and other emergency management issues.

The NSTN currently is a collaborative effort that involves a number of partners facilitated by the Nebraska Hospital Association. The major users of the NSTN include Nebraska hospitals, public health departments and the State and Regional Bioterrorism Labs. The NSTN connections between hub hospitals and their connecting rural hospitals

were initiated and tested in August of 2004. All Nebraska hospitals and health departments will be connected to the NSTN in 2005-2006.

The telehealth telecommunications services are anticipated to:

- Increase the ability to diagnose patients' illnesses;
- Improve the quality and administration of medical services;
- Strengthen rural physicians' ties to specialty care;
- Alleviate the isolation of rural providers;
- Enhance the ability to attract and retain primary care physicians, medical professionals and support staff;
- Facilitate the training of health professionals in rural communities;
- Enable patients to stay close to home for their care; and
- Improve access to consultations with mental health practitioners, radiologists, and other medical specialists.

Urban and some rural communities continue to face challenges of an influx of new immigrants from various parts of the world. These immigrants bring with them a multitude of cultural and language needs and in some cases no health care coverage. A particular challenge in delivering health care services in Douglas County has been the arrival of Sudanese immigrants. The Hispanic immigrants from Mexico, Central and South America are often uninsured or underinsured, which impacts their access to medical and dental health services.

Systems building activities with medical providers and tertiary care centers and children's hospitals have been less active in recent years. A previous activity of Nebraska's Title V MCH/CSHCN programs was the routine site visits to neonatal intensive care units and routine training and technical assistance to "Level I" birthing hospitals. Organizational changes and limitations on resources have significantly limited active involvement in perinatal care system quality assurance. More recently, the Office of Family Health has had an increased role in Medicaid managed care quality assurance activities, but sees great potential for additional work in this area.

Nebraska's CSHCN population receives sub-specialty care through the Title V funded Medically Handicapped Children's Program (MHCP) that recruits health care professionals to form sub-specialty clinics to travel in teams to rural areas of Nebraska. These teams include nutritionists, physical therapists, medical social workers, sub-specialty physicians and nurses. In addition, Nebraska's educational system has divided Nebraska into Educational Service Units (ESU). Each ESU has a number of trained speech pathologists, school nurses, audiologists, physical therapists, and psychologists.

MHCP is administrated within the Department of Health and Human Services Finance and Support, Home and Community Based Services for Aged, and Physically Disabled. The administrator for this unit is the Title V/CSHCN Director. Other programs housed within this unit include: Aged and Disabled Waiver, Katie Beckett Plan Amendment Services Coordination, Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, Adult Protective Services, SSI Disabled Children's Program, Nebraska Resource Referrals System, Genetically Handicapped Persons Program, Early Intervention Waiver, and the Early Intervention and Medicaid in public Schools Programs, which are co-administered with the Nebraska Department of Education.

As stated above, Home and Community Based Services for Aged, and Physically Disabled operates the SSI-Disabled Children's Program (DCP) for those children eligible for SSI who are under age 16 and require rehabilitative and support services not otherwise provided by the Nebraska Medical Assistance Program (Title XIX, Medicaid). Services provided through the Nebraska SSI-Disabled Children's Program include transportation to enable children to obtain diagnostic and/or treatment services, sibling care, attendant care, respite care, meals and lodging while traveling to obtain medical care, personal care needs, utilities related to special high electrical use support equipment (e.g., nebulizers, oxygen concentrators, etc.), architectural modifications including wheelchair ramps, and specific items of equipment to maintain or improve functioning..

Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral palsy, the Disabled Persons and Family Support Program, and other private non-profit programs all participated in coordinated funding meetings to assure that individuals receive services for which they are eligible. For nearly 20 years, this group of providers and advocates has met to discuss individual cares and find solutions, which make the most efficient use of program resources.

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP on a regular basis of children determined eligible for SSI, at which time MHCP sends a letter to the family describing possible services they may receive and how to apply. The DDU and MHCP also worked together last year to compile a list of those impacted by the federal change in the definition of "disability" for SSI. All such persons were sent notices from MHCP and DDU, which provided the toll-free telephone number of the Parent Training Center in Omaha, a private non-profit agency. This agency made families aware of their potential denial of SSI and the process to appeal the denial.

## **B. Population-Based Services**

Newborn Screening Title V funds partially support the Nebraska Newborn Screening Program (NNSP). NNSP screens for six mandated disorders: biotinidase deficiency (about 1:25,000), congenital primary hypothyroidism (about 1:6,000), galactosemia (about 1:80,000), hemoglobinopathies (about 1:600), and phenylketonuria (PKU) (about 1:12,000), and MCAD. A total of 26,391 (99.8%) infants were screened for these

disorders in 2004, infants who were not screened expired prior to 48 hours of age. In addition, 30 disorders are available as a supplemental screen (free of charge), with 96% of newborns benefiting from this option. This program is currently proceeding with regulatory changes to add Cystic Fibrosis and Congenital Adrenal Hyperplasia.

Infants diagnosed as positive for the following disorders were detected and facilitated into treatment through newborn screening in 2004: 6 infants with partial (treated) biotinidase deficiency; 8 infants with congenital primary hypothyroidism; 0 infants with sickle cell disease and two with sickle hemoglobin-C disease; 1 with phenylketonuria; and 4 with MCAD.

Newborn Hearing Screening is a statutory provision passed in 2000. By 2003 100% (67/67) of birthing hospitals were participating in newborn hearing screening, up from 11 in 2000. These hospitals screen 98.2% of all births in the state. In 2003, 901 infants were referred for follow-up screening and assessment and of those 26 were identified with permanent childhood hearing loss (1:1000).

Lead Screening In 2003, fewer than one in ten (7.8%) of Nebraska children under the age of six were screened for elevated blood lead levels. Lead can have significant detrimental physical, behavioral, and cognitive development effects on young children. Young children living in homes built prior to 1950 are at significantly greater risk of exposure to lead. Homes built before 1950 almost always contain lead-based paint and 38% of the homes in Nebraska were built prior to 1950. Homes built prior to 1978 may also present a risk for lead exposure.

In Nebraska, 11,198 children were reported having been screened for elevated blood lead levels in 2003. This number reflects an increase of 2,807 children from the number tested in 1998. In 2003, 490 (4.3%) of children screened had blood lead levels above the threshold of 10µg/dL. Nationally, 3.1% of children screened had high blood lead levels.

Nutrition Services Children with special health care needs in Nebraska currently participating in CSHCN multi-disciplinary clinics indicated that almost 23% (92) require follow-up nutritional services. Few licensed medical nutritional therapists (LMNTs) provide nutritional services to CSHCN. LMNTs indicated that they require additional training and education to provide services to CSHCN. Most nutrition services for MCH population are categorical in nature, with no comprehensive state plan cutting across funding streams.

Immunization Nebraska has 55 public immunization sites serving 85 of Nebraska's 93 counties. In addition 213 private Vaccine for Children providers are available across the State. The Nebraska Immunization Program provides vaccines to the sites. The goal of the Immunization Program is to have at least 90% of all children immunized by 2 years old of age. Currently the immunization rate for 2-year olds in the U.S. is 77.9% and Nebraska's immunization rate is 78.1% for 2-year olds and younger.

An Immunization registry supports all public clinics except Lancaster County. Because of fragmented and incomplete immunization records, immunization providers find it hard to determine whether children are up-to-date on their immunizations. Children often visit more than one immunization clinic or private physician to receive vaccinations. In addition, the ability to use data to measure immunization levels, identify who never started their vaccinations on time, who started and has fallen behind, and where to allocate funds in order to impact on the largest number of children with the greatest need is critically important. Nebraska Title V continues to provide registry funding to ensure its sustainability of the current registry while and exploring an registry for implementation in both public and private settings.

Injury Prevention The NHHSS Injury Prevention & Control Program in conjunction with the Nebraska Injury Prevention Advisory Committee focus their efforts on providing education and materials, surveillance, and a great deal of collaboration with already existing public health programs, including those funded by Title V. In the past year they have produced Nebraska Injury Prevention State Plan 2004 the Nebraska Injury Surveillance Report 2004, and the 2004 Report on Unintentional Fall Related Injuries all affecting the MCH/CSHCN population.

The Nebraska SAFE KIDS Coalition works to prevent the leading cause of death and disability to children age 14 years and under: unintentional injuries. Coalitions and chapters have been established across the state. Emphasis is placed on education of both children and parents through media campaigns, direct education, and community events. Nebraska SAFE KIDS Campaign, coordinated through the Nebraska Health and Human Services System, was established in 1993 to address unintentional injuries to children 14 and under. The Campaign is part of the National SAFE KIDS Campaign founded by the Children's National Medical Center in Washington, D.C.

Outreach/Public Education Title V funds the Healthy Mothers, Healthy Babies Help line, a toll free hotline for parents to call about services for their children. Title V also funds a breastfeeding hotline and UNMC's Munroe-Meyer Institute receives funding for their teratogen services through MHCP.

One of the gaps in population based services provided is around Sudden Infant Death Syndrome (SIDS). While the nationwide Back to Sleep campaign has reduced the number of SIDS cases nationally by 40%, SIDS continues to be a leading cause of infant mortality in Nebraska. Title V has begun a statewide initiative to address SIDS in Nebraska. A public awareness campaign is scheduled to kick off in October 2005.

Title V has also funded the Nebraska Breastfeeding Initiative and its Steering Committee. This committee has met three times since the beginning of the year, and has developed a set of draft goals and strategies. Four events are planned for August and September to promote August Breastfeeding Awareness month. Volunteers from the Committee will present at the Nebraska Public Health Association Conference in September. In addition, the Committee will host a reception in conjunction with the Breastfeeding: Baby's Natural Choice Conference. This conference is sponsored by Olson Women's Health Center, University of Nebraska Medical Center - Omaha. Finally, two stakeholder

forums will be held to gather additional input from key stakeholders regarding the draft goals and strategies in order to develop an action plan for future activities. The Committee hopes to build an ongoing statewide collaborative to connect persons and organizations to share best practices, offer mentoring, and develop joint activities.

Finally, an program implemented in 2004 is "First Connections with Families" developed by the Nebraska Department of Education, in cooperation with the Nebraska Health and Human Services System, to meet the requirements of the Nebraska Read, Education and Develop Youth Act. The booklet contains information about child development, reading to children, and child health and safety. In CY 2004, this booklet was distributed to 26,323 Nebraska families with newborn babies.

### **C. Infrastructure Building Services**

As stated earlier Nebraska has significant gaps in the availability of primary care providers. Added to that, state-level public health resources are often categorical, with fragmented capacity in the core functions. These issues have historically impacted infrastructure building for the MCH and CSHCN population.

One of the most significant activities to address public health infrastructure is the creation of the local health districts across the state. In 2001 only 22 of Nebraska's 93 counties were served by a local health department (16 total). Today, there are 25 local and district health departments representing all of Nebraska's 93 counties. While this work began in 2001 with state legislation allocating start up funds it has been in the last few years that the infrastructure has started to build, especially in the MCH arena.

In the last sub-granting funding cycle Nebraska Title V (2002-2005) created a set-aside for local health departments to build MCH infrastructure. Nebraska was then able to fund 14 health departments in the past three years to build MCH capacity. The health departments were asked to conduct activities along the following continuum:

- 1) participate in learning activities to gain any variety of information relative to MCH;
- 2) convene local collaboratives or bring MCH considerations into existing collaboratives;
- 3) join state-level development of MCH standards, assessment of needs, planning cycle;
- 4) assess, design, and build data systems for collecting, analyzing, and sharing data regarding overall MCH health status and community resources and/or specific conditions and risks;
- 5) establish health services standards/guidelines and conduct a variety of training to support these systems and standards;
- 6) facilitate coordinated systems of comprehensive health care services; and
- 7) develop a local surveillance system of health conditions to improve local programming and serve as an early warning system for local and state programs.

Of the 14 projects funded eight participated in an assessment of MCH health status within their jurisdiction. In the up-coming funding cycle Title V anticipates further collaboration with the Local Health Departments.

Since the last needs assessment Nebraska has improved on the core public health function of assessment. In 2003 the Office of Family Health created the MCH Epidemiology Unit which staffs the State Systems Development Initiative, Child Death Review Team, and the Pregnancy Risk Assessment Monitoring System together with data management for Title V and the needs assessment. Through the MCH Epidemiology Unit Nebraska has just completed the first Oral Health Survey of third graders. Other projects in the pipeline include analysis of the SLAITS National Survey of Children's Health and a proposed perinatal service survey.

Data capacity for CSHCN continues to be addressed through Nebraska's SSDI project. Use of hospital discharge data is being explored as a means for gathering more population based data on CSHCN, to supplement programmatic data. Nebraska has and continues to try and improve the use of the birth defects registry. Dr. Mulvihill's consultation offers new ideas on ways to improve the data gap by:

- Survey relevant state, public and private agencies to determine what information they have related to CSHCN (e.g. Head Start; condition specific support groups such as Autism society, American Diabetes Association; United Way; United Cerebral Palsy, the Arc)-Create a matrix of relevant disability-serving agencies and available data
- Make better use of the birth defects registry to identify children and forecast service needs
- Investigate what additional family surveys might have been done in the past

One new program addressing a traditional infrastructure gap in Nebraska is "Together for Kids and Families" a two-year planning grant awarded to Nebraska Health and Human Services System in 2003, funded through the State Early Childhood Comprehensive Systems (SECCS) Grant Program administered by the Maternal and Child Health Bureau, US Health and Human Services. This project is designed to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The Governor appointed Early Childhood Interagency Coordinating Council serves as the Project Advisory Committee. The Project Leadership Team of 50-plus persons from across the state represents various agencies and organizations that are involved/interested in the health and well being of young children and their families. An early childhood comprehensive systems strategic plan will be completed by December 2005 and an application has been submitted for three years of implementation funding.

The Nebraska Newborn Hearing Screening Program was recently awarded an Early Hearing Detection Integration (EHDI): Tracking, Surveillance and Integration Cooperative Agreement through the Centers for Disease Control and Prevention. The goal of the Cooperative Agreement is to ensure that all newborns' hearing is screened and

that each young child with a hearing loss reaches optimal development through appropriate follow-up services by providing complete, timely, and accurate information through a convenient point of access. This goal will be achieved through development and implementation of an electronic reporting of all test results, referrals, evaluations, and outcomes. The data set (integrated with electronic birth certificate registry) will be linked to the birth defect registry and death certificate file in the first year then linked with the CONNECT data system (Early Development Network /Medically Handicapped Children's Program (Children with Special Health Care Needs)) in the second year. Additional linkages such as with WIC are proposed for the third year.

In addition to these efforts Nebraska was recently awarded a maternal depression grant to begin building much needed systems capacity in the area of mental health.

To objectively examine the State's capacity to provide public health services, Nebraska chose to use the Capacity Assessment for State Title V (CAST-5) process with a small group of stakeholders in four half-day meetings over a six week period.

This set of tools is designed to help assist state MCH programs in examining their organizational capacity to carry out the ten essential services of Maternal and Child Health. Nebraska used portions of the revised Second Edition. The tools utilized in Nebraska's assessment were:

- ◆ Core Questions
- ◆ Process Indicators Tool
- ◆ SWOT Analysis

Key findings in this process were identified as "Opportunities to Improve MCH Capacity" by the small groups of stakeholders. The participants concluded that for the core function of assessment, Nebraska MCH could better use and share data including on-going measurement/tracking of health indicators. In addition a step for enhancing policy development capacity would be the development of a vision/mission statement, as well as better connecting the assessment process to planning. For the core function of assurance the stakeholders saw opportunities in the areas of workforce development (including scope of practice) and promotion of best practices through research and policy.

Complementing and expanding the CAST-5 process was the use of the National Public Health Performance Standards assessment instrument for state public health systems. The assessment was planned and conducted by the Office of Public Health during a full day retreat held June 2005. The findings will be used to develop a strategic plan for public health in Nebraska, updating the previous plan created as a part of the Turning Point Project. The Office of Family Health will be seeking technical assistance in the bridging of CAST-5 and the assessment using the National Public Health Performance Standards, to develop infrastructure strategies specific to MCH.

## **V. Nebraska's Ten Priorities**

The needs assessment prioritization process yielded seven priorities (1-7 below) for the MCH populations (women, infant, children, and youth) and three priorities for the CSHCN population (8-10 below). The following are the ten priorities, and the State Performance Measure (when appropriate) chosen to assist with monitoring the need. The State Performance Measures were chosen based on the priority content, the absence of a National Performance Measure, and the availability of an annual data set.

**1. Reduce the rates of overweight among women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.**

**State Performance Measure:** Percent women (18-44) with healthy weight (BMI),

This is a new State Performance Measure. The healthy weight of women will serve as a proxy for children and youth. The data set available to track this measure is the Nebraska Behavioral Risk Factor Surveillance System (BRFSS).

**2. Reduce the percent of women of childbearing age, particularly pregnant and post-partum women, and adolescents who use tobacco *and* reduce the percent of infants, children and youth exposed to second hand smoke**

**State Performance Measure:** Percent of women of childbearing age who report smoking in the last 30 days.

This is an existing State Performance Measure. The smoking status of women will serve as a proxy for youth and environmental exposure to infants and children. The data set available to track this measure is the Nebraska BRFSS.

**3. Reduce rates of premature and low birth weight births for all women, with attention to on adolescent pregnancy.**

**State Performance Measure:** Percent premature births (births<37 weeks)

**State Performance Measure:** Rate (per 1,000) of infant death to adolescents (age 15-17)

These are new State Performance Measures. Health Systems Indicators 1 and 2 monitor low birth weight births. The data set used to track annual progress will be the Vital Records Birth Certificate Registry as well as the linked Birth/Death Certificate Registry file.

**4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.**

**State Performance Measure:** Hospitalization for unintentional injuries (per 1,000) for children and adolescents

This is a modification of an existing State Performance Measure. The data set used to monitor progress will be the Hospital Discharge Data.

**5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children**

**State Performance Measure:** Hospitalization for intentional injuries (per 100,000) for children

This is a modification of an existing State Performance Measure. The data set used to monitor progress will be the Hospital Discharge file.

**6. Reduce the rates of infant mortality, especially racial/ethnic disparities.**

**State Performance Measure:** Incidence of confirmed SIDS cases (per 1,000 live births) among African American and Native American infants

**State Performance Measure:** The percent of African American women beginning prenatal care during the first trimester

These are existing State Performance Measures. The source data is the Vital Records Birth Certificate Registry.

**7. Reduce alcohol use among youth.**

**State Performance Measure:** Percent of teens who report use of alcohol in last 30 days

This is an existing State Performance Measure. The source of data is the bi-annual Youth Behavior Risk Survey (YRBS)

**8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.**

**State Performance Measure:** Percent of women age (18-44) who reports mental health not good 10+ days of past 30

This is a new State Performance Measure. The data set available to track this measure is the Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Although, this priority came from CSHCN workgroup the only available annual data set measures the mental health of women.

**9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.**

**National Performance Measure:** National Performance Measure #4 the percent of CSHCN have adequate private/public insurance to pay for the services they need.

**10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.**

**National Performance Measure:** National Performance Measure #6 the percent youth with CSHCN who receive services necessary to make transition to all aspects of adult life.

**VI. Summary**

To Summarize Nebraska's 10 priority needs determined in 2005 are

1. Reduce the rates of overweight women, youth, and children by increasing participation in sufficient physical activity and improving nutrition.
2. Reduce the percent of women of childbearing age, particularly pregnant and post-partum women, and adolescents who use tobacco *and* reduce the percent of infants, children and youth exposed to second hand smoke.
3. Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy.
4. Reduce the rates of hospitalizations and deaths due to unintentional injuries for children and youth.
5. Reduce the number and rates of child abuse, neglect, and intentional injuries of children.
6. Reduce the rates of infant mortality, especially racial/ethnic disparities.
7. Reduce alcohol use among youth.
8. Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.
9. Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.

10. Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.

**Nebraska's priorities were developed on the following time line and activities:**

TIME LINE FOR NEEDS ASSESSMENT ACTIVITIES	
Summer 2002	Needs Assessment Committee (NAC) forms
July 2003	Needs Assessment Charter is finalized
Summer 2003	First Graduate Student Internship Program (GSIP) Intern develops a Matrix of Indicators and presents to the NAC
September 2003	NAC meets and reviews proposed indicators for women, infants, children, and youth
Summer 2004	Contractor, Second GSIP Intern, and Family Health Staff begin to pull current data for indicators. Contract is executed with Family Health Outcomes Project (FHOP) to facilitate the prioritization process.
September 2004	NAC convened by videoconference Indicators are finalized based on availability of data
October 2004	Dr. Mulvihill consults with Nebraska on the needs assessment process for CSHCN. NAC meets via videoconference. CAST-5 work group forms (conducts process over four meetings).
November 18, 2004	FHOP consults with Family Health; NAC meets to determine prioritization criteria
December 2004	CSHCN becomes a separate work group chaired by Dr. Reed. The CSHCN workgroup follows a parallel although not identical process
September-January 2005	Family Health Staff input and analyze data for significant trends, disparities, and against benchmarks (HP2010 and National rates)
January -March 2005	Subcommittee workgroups are formed for women, infants, children, youth and CSHCN. Meetings are held to determine which indicators should be considered for priority needs.
March 16, 2005	FHOP returns to facilitate the NAC prioritization process (from 20 problems to seven priorities)
March 24, 2005	The CSHCN workgroup determines the remaining three priority needs

The data process began in 2003 with a comprehensive literature review by the first intern, with recommendations on health status indicators relevant to Nebraska's MCH/CSHCN populations. Following up on this work staff assembled a database of approximately 425 indicators addressing the states target populations (women 20-44, infants 0-1 children 1-9, and youth 10-19). Data was collected in the fall of 2004, in the following forms, when available:

- 5) Data from 1995-current (in most cases 2003);

- 6) Data by race/ethnicity;
- 7) National rates
- 8) Healthy People 2010 objectives

Once the data was assembled it was tested for statistical significance. These indicators were used by the Needs Assessment Committee (NAC) to access the population and then identify and prioritize needs. The creation of a separate CSHCN Work Group was a key recommendation of Dr. Beverly A. Mulvihill, who served as a consultant to the Department in October 2004. Therefore the CSHCN population had a separate workgroup that followed a parallel process.

## **VII. The Fact Sheets**

The following are the products of the five workgroups charged with interpreting data and assessing the MCH population.

### **A. Women**

#### **Breast Cancer**

##### **Address Breast Cancer Disparities**

According to the Cancer Registry and CDC African American women in Nebraska have higher rates of breast cancer mortality (42.9/100,000) yet lower rates of breast cancer diagnosis (109/100,000) as compared to Caucasian women, the state, the nation and HP2010. This is the case even though African American women report the highest rates of screening for any sub-population in the state. This indicates that African American women are dying at a higher rate from a condition that can be effectively treated if diagnosed early and treated aggressively.

Cancer is one of the top 5 causes of death for women in Nebraska

##### **Effective Intervention**

According to AHRQ, despite substantial research progress, breast cancer continues to take a heavy toll, especially among African American women. Research is in progress. The following interventions based on recent findings have **promise** for increasing survivorship:

- ◆ Patients decide treatment, enhance communication about options
- ◆ Increase breast-conserving surgery and radiation treatments for African American women.
- ◆ Cultural specific and community-based strategies for increased mammography/early detection and decreasing missed appointments
- ◆ Support groups

### **Disproportionate Effects Among Subgroups of the Population**

The CDC National Center for Health Statistics provides the following death rates:

The average annual age-adjusted death rates for breast cancer per 100,000 persons, by race, 1997–2001

	Nebraska	National
Overall	24.4	27
White	24	26.4
Black	42.9	35.4
Hispanic	-	17.2
Asian	-	12.6
Native American	-	13.6

### **Problem is worse than the Benchmark or Increasing**

African American women in Nebraska are experiencing mortality from breast cancer at rates that are **higher than the nation (see above), and HP2010** of 22.3.

### **Severity of the Consequence**

Death  
Depression  
Disability

### **Impetus for Change**

- ◆ Broad policy support
- ◆ Every Woman Matters Program - including media campaign addressed to African American women
- ◆ State law requires insurance companies to pay for one mammogram per year
- ◆ Private organizations conduct fundraising and awareness events such as the Susan G. Komen Race for the Cure
- ◆ There is a lot of support for breast cancer in general, but more needs to be targeted at African American women.

### **Large number of People Affected**

In 2004, the American Cancer Society estimates

- 1,290 new cases of breast cancer will be diagnosed among women in Nebraska.
- 240 women will die of breast cancer in Nebraska.

A rate of 42.9/100,000 (1997-2001) equates to 6-7 African American women dying from Breast cancer in 2003<sup>1</sup>.

---

<sup>1</sup> Based on population projections from 2000 US census

## Tobacco Consumption

### **Decrease Smoking among Women (Particularly Pregnant/Post Partum Women).**

According to BRFSS Nebraska women smoke at significantly higher rates compared to the nation (25.2% vs 20.0%) and more than twice the HP2010 Objective (12.0%). Nearly half of all Native American women in Nebraska smoke.

According to NE PRAMS 14.8% of NE women smoke during pregnancy compared to the national average of 11.0% and HP2010 Objective of 1%. In addition, 21.4% of postpartum women are smoking which is also higher than the

These rates indicate that Nebraska women are at greater risk for tobacco – associated illnesses and poor birth outcomes, with particularly greater risks for Native American women.

### **Effective Interventions Available**

According to CDC's Guide to Community Preventive Services there is **proven evidence –based** interventions that prevent initiation and increase cessation

Advertising/Social Marketing – with interventions

Increase price of tobacco products

Provider education and instruction to patients - preconception, prenatal, and post-partum

Reduce patient cost for treatment - Classes, Medication (patch or gum)

Quit Line support with interventions

**Culturally appropriate materials available**

### **Disproportionate Effects Among Subgroups of the Population**

46.2%<sup>2</sup> of **Native American women** in Nebraska report currently smoking, nearly twice the rate of the overall population and 30.6%<sup>3</sup> (2003) report smoking during pregnancy more than twice the overall state rate of 14.9%.

### **Problem is worse than the Benchmark or Increasing**

Nebraska **women** of childbearing age, **including** women who are **post-partum**, smoke at rates that **more than twice the HP2010 Objective** of 12.0%

**Pregnant** women smoke at rates that **greatly exceed the HP2010 Objective of 1%.**

### **Severity of the Consequence**

**Women**

Mortality

**Their infants**

Still birth

<sup>2</sup> NE BRFSS, averaged over 1993-2003

<sup>3</sup> NE Vital Statistics

Lung and other cancers  
Cardiovascular disease  
Menstrual function  
Infertility  
High risk pregnancy  
Bone density and fractures  
Asthma  
Respiratory problems

Low Birth Weight/Prematurely  
Infant Mortality  
Associated with SIDS  
Higher rates of ear infection

### **Impetus for Change**

Tobacco Free Nebraska

- To identify and eliminate disparities related to tobacco use and its effects among different population groups
  - To promote [quitting](#) the use of tobacco among adults and youth
- Office of Family Health has produced/available materials targeted at women of childbearing age (pregnancy) for providers to use.  
Nine County-level Tobacco Coalitions in Nebraska  
Local and potential state smoking bans/laws

### **Large number of People Affected**

Estimated number of women who currently smoke = 80,000<sup>4</sup>

Estimated number of pregnant smokers = 3,500<sup>5</sup>

Estimated number of post-partum smokers = 5,000<sup>4</sup>

Estimated number of Native American women who currently smoke = 2,300<sup>5</sup>

---

<sup>4</sup> Based on population projection from 2000 US Census and BRFSS estimate of current smokers

<sup>5</sup> Based NE PRAMS estimate

<sup>6</sup> Based on population projection from 2000 US Census and BRFSS estimate of current smokers

## Overweight

### **Decrease Overweight Women of Childbearing Age**

According to BRFSS, 24% of women in Nebraska are overweight compared to 21.4% nationally. In NE rates are even higher for African American women (31.9%) and Hispanic women (36.5%). Therefore, Nebraska women particularly African American and Hispanic women are at increased risk for chronic illnesses such as: cardiovascular disease, diabetes, and poor birth outcomes.

### **Effective Intervention**

According to the NIH's Clinical **Guidelines** on Identification, Evaluation, and Treatment of Overweight and Obese Adults the following are **proven evidence- based** interventions examination of random clinical trials (rich body of evidence):

- ◆ Dietary Therapy – low calorie and very low calorie diets
- ◆ Physical Activity – for weight loss and weight control
  - Moderate-intensity for 30-45 minutes 3-5 days a week
- ◆ Life style Therapy- behavior change in conjunction with reduced calorie diet and physical activity

### **Disproportionate Effects among Subgroups of the Population**

African American (31.9%)<sup>7</sup> and Hispanic (36.5%) women have rates of overweight that are significantly higher than the state average (24.0)

### **Problem is worse than the Benchmark or Increasing**

**Overweight** – Nebraska is **significantly higher than the national average Obesity** – Nebraska is **significantly higher than the HP2010 Objective** of 15% and is **increasing**.

- ◆ significantly lower 5-a-Day Fruit/Vegetable consumption (17.2%)<sup>6</sup> as compared to the US (27%)<sup>7</sup>
- ◆ NE has a significantly higher rate of excessive prenatal weight gain (51.8%)<sup>8</sup> as compared to the US (30.8%).<sup>9</sup>

### **Severity of the Consequence**

Premature Death

Cardiovascular Disease

Heart disease is the third leading cause of death to women (20-44) in Nebraska

Diabetes

Cancer

---

<sup>6</sup>NE BRFSS

<sup>7</sup> CDC BRFSS

<sup>8</sup> NE PRAMS

<sup>9</sup> CDC PNSS

Breathing Problems  
Arthritis  
Reproductive Problems  
Lower back pain  
Depression  
Discrimination  
Eating Disorders  
Poor birth outcomes

### **Impetus for Change**

Chief Medical Officer identifies obesity as problem for Nebraska  
Various wellness programs across state sponsored by:  
    Insurance Companies  
    Employers  
    Non-profits  
    Clinics  
Federal initiatives  
Communities addressing walkability

### **Large number of People Affected**

Estimated number of women age 20-44 who are **overweight or obese =132,000<sup>10</sup>**

Women are the gatekeepers of nutrition and health for their families.

---

<sup>10</sup> Based on 2000 US population Census and BRFSS estimates

## Prenatal Care

### Increase Early Entry into and Adequacy of Prenatal Care

According to Nebraska PRAMS and Vital Statistics between 79% and 84% of Nebraska women are receiving early prenatal care (first trimester) which is lower than the Healthy People 2010 Objective of 90%, indicating that Nebraska women are at risk for poor maternal and infant outcomes. Early prenatal care and number of prenatal visits are both used in the Kotelchuck index, which measures adequacy of care. According to Vital Statistics, Nebraska 73.9% of women received adequate prenatal care. This rate is below both the national average of 80% and the HP2010 Objective of 90%.

- ◆ According to NE PRAMS less than half (44.8%) of pregnant women access dental care. Periodontal disease during pregnancy is thought to be associated with low birth weight.

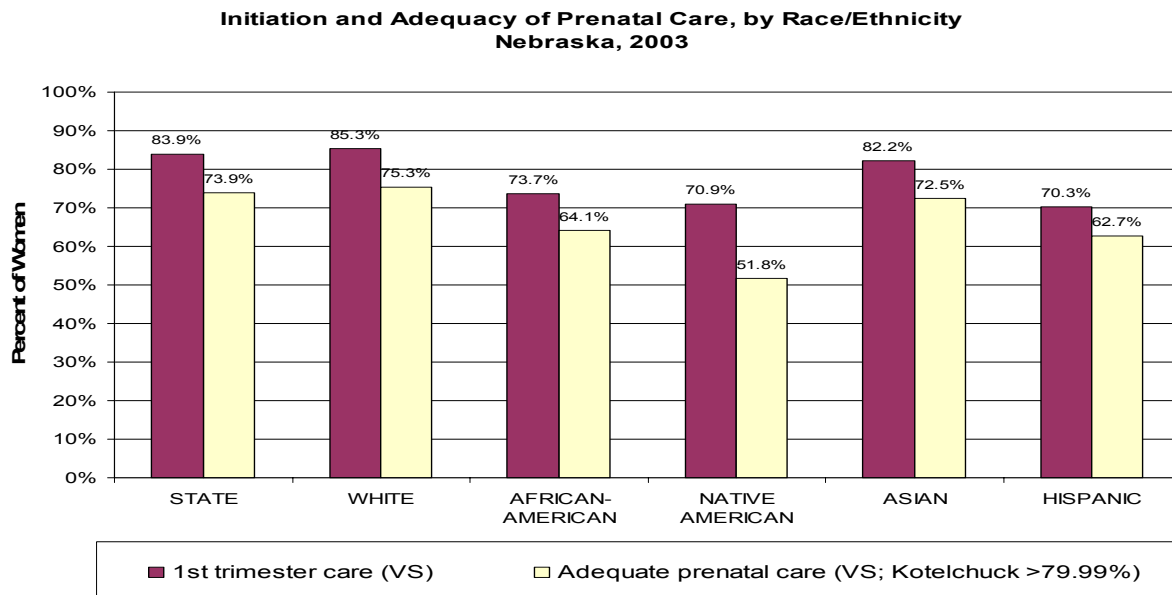
### Effective Intervention

According the American College of Obstetricians and Gynecologists interventions that are **proven to reduce barriers** to early and adequate prenatal care are:

- ◆ Remove access barrier such as language, transportation, child care, interference by others
- ◆ Referrals to social service agencies
- ◆ Intended Pregnancy
- ◆ Remove financial barriers
- ◆ Knowledge of where to receive prenatal care

### Disproportionate Effects Among Subgroups of the Population

Disparities exist for all racial/ethnic groups.



**Problem is worse than the Benchmark or Increasing**

- ◆ Rates of early prenatal care have been decreasing at statistically significant rates since 1995. Therefore the **problem is increasing**.
- ◆ Early prenatal care is **significantly lower than the HP2010 Objective** of 90%
- ◆ Adequate prenatal care are **below the national rate (75%) and HP2010 Objective** of 90%

**Severity of the Consequence**

Low Birth Weight and Very Low Birth Weight –leading to infant mortality

Prematurity – leading to infant mortality

Poor nutrition and inadequate weight gain during pregnancy

High cost for infant care

High cost for post-partum care

**Impetus for Change**

- ◆ NE Medicaid retains presumptive eligibility for pregnant women
- ◆ Legislative Bill 264 for child maltreatment that references Home Visitation and Prenatal Care
- ◆ Omaha Healthy Start primarily targets African American women  
Northern Plains Healthy Start primarily targets Native Americans
- ◆ Baby Blossoms in Omaha – collation working on infant mortality

**Large number of People Affected**

2003 number of women **not receiving early prenatal care** = 4,165<sup>11</sup>

2003 number of women **not receiving adequate prenatal care** = 6,770<sup>1</sup>

---

<sup>11</sup> Based on 2003 NHHSS Vital Statistics

## STD's

### **Reduce Sexually Transmitted Disease Rates among Women**

According to Communicable Disease Surveillance, Nebraska women of child bearing age have sexually transmitted disease (STD) rates (gonorrhea and chlamydia) that have been increasing at statistically significant rates since 1995. Racial and ethnic disparities in new infections of HIV/AIDS also exist. These rates indicate that Nebraska women are at increasing risk of infertility, pregnancy loss/infant death, and cervical cancer.

### **Effective Intervention**

According to CDC's Clinical Prevention **Guidelines**, sexually transmitted disease treatment guidelines; 2002 the following interventions are **proven and evidence based**:

- ◆ Educate persons at risk on safe sex behavior– risk reduction
- ◆ Identify those who need treatment – both asymptomatic and symptomatic unlikely of seeking treatment
- ◆ Test and treat
- ◆ Partner Identification – evaluate, treat, counsel partners of persons who are infected

### **Among Subgroups of the Population**

HIV infection rates for African American (40.9/100,000) and Native American (21.7/100,000) women are drastically and significantly higher than for Caucasian (1.3/100,000) women.

### **Problem is worse than the Benchmark or Increasing**

Infection rates of **chlamydia and gonorrhea** are **increasing** - and are projected to reach the current national rate by 2007.

The new infection rate for **gonorrhea** is **higher than the HP2010 Objective** of 19.0.  
The new infection rate for **HIV/AIDS** is **higher than the HP2010 Objective** of 1.0.

### **Severity of the Consequence**

#### **Women**

Mortality – HIV/AIDS  
Infertility  
Cervical cancer

#### **Their Infants**

Stillbirth  
Low birth weight  
Conjunctivitis

Cirrhosis	Pneumonia
Enhanced transmission of HIV/AIDS	Meningitis
<b>High cost to treat</b>	<b>Congenital abnormalities</b>
Pregnancy loss/infant death	Chronic liver disease and cirrhosis

### **Impetus for Change**

Douglas County Board of Health has declared the increasing rates of STD's to be an epidemic and have dedicated approx. \$100,000 for a media campaign to increase public awareness through TV ads, billboards etc. The news media has picked up on the trends and has published articles in the local paper every two to three months over the past year.

Reproductive Health/Family Planning clinics test and treat utilizing state and federal funds.

### **Large number of People Affected**

**2003 Total cases of Chlamydia and Gonorrhea = 4,359**

**2003 Total new Infection HIV/AIDS =15**

**2003 Number of women living with HIV/AIDS =307**

These numbers do not account for partners/multiple partners effected.

Because STD's are contagious, there is an on-going potential for an "epidemic", e.g. as currently seen in Douglas Co.

## B. Infants

### Premature births and low birth weight

**Babies born preterm** are at risk for serious health problems, including medical complications, long-term disabilities and death. Very premature babies have the highest risk of death and lasting disabilities, such as mental retardation, cerebral palsy, lung and gastrointestinal problems, and vision and hearing loss. According to Nebraska Vital Statistics, the rate of premature births has increased during the period of 1995-2003. The 2003 rate for all births was 9.7% and for singleton births it was 7.7%, compared to the Healthy People 2010 Objective of 7.6%. Significant disparities exist, with the rate for preterm African American singleton births being 12%.

According to NE Vital Statistics, the prevalence of **Low Birth Weight (LBW)** is 6.9% and **Very Low Birth Weight (VLBW)** is 1.2%, and both rates are higher than the HP2010 Objectives (5% and 0.9% respectively). Low birth weight, and particularly VLBW, infants are at a greater risk of death within the first month of life, as well as at increased risk for developmental disabilities and illness throughout their life.

- Among singleton births, the African American rate has been consistently more than two times the state rate for the period of 1995-2003, for both LBW and VLBW.
- The LBW rate for the Native American and Asian populations have consistently higher than the state rate for the period of 1997 – 2003.
- Urban populations in 2003 had higher incidence of LBW (7.5%) than rural populations (6.2%).

#### Criterion #1: Effective Interventions

- Proven interventions:
- Antibiotic treatment for bacterial vaginal infection helps reduce the rate of premature delivery (Patient Outcomes Research Team, AHCPR)
- There is an association with aspirin therapy with improved pregnancy outcomes such as less preeclampsia, less premature rupture of membranes, fewer preterm birth, higher mean birthweight, and fewer small-for-gestational-age births (Ibid.)
- Drug, alcohol, and tobacco cessation during pregnancy helps lower the risk (Ibid.)
- Smoking cessation interventions reduce the prevalence of low birth weight and increase birth weight among pregnant women who quit as a result of intervention (Health Development Agency, United Kingdom)
- Evidence supports the effectiveness of calcium supplementation for a reduction in preterm birth and the incidence of low birth weight in pregnant women. (Ibid.)
- Promising interventions or interventions with inconclusive evidence
- Multicomponent prevention programs, including risk assessment, education, advice, self-monitoring of uterine activity, antenatal care, support systems, and specific obstetric interventions) (da Silva, Dept. of Pediatrics, The University of Western Ontario) and (Canadian Task Force on Preventive Health Care)
- Diet supplementation in high-risk women to prevent low birth weight (Canadian Task Force on Preventive Health care)

**Criterion #2: Disproportionate Effects Among Subgroups of the Population**

- African Americans are 2x greater than the state LBW and VLBW rate on and a half the state rate of pre-mature births
- Native Americans and Asians LBW consistently higher than state rate
- Infants born to teens 2-6x more likely LBW than those born to older mothers
- Urban residents higher incidence of LBW

**Criterion #3: Problem is worse than the Benchmark or Increasing**

- Prematurity state rate (7.7%) the benchmark (7.6%)
- Prematurity is increasing
- LBW state rate is worse than the benchmark
- LBW rates of some subgroups are much worse than the state rate
- LBW shows a linear increase

**Criterion #4: Severity of the Consequence**

Prematurity results in serious health problems:

- medical complications
- long-term disabilities
- death

Very premature babies have the highest risk of death and lasting disabilities:

- mental retardation
- cerebral palsy
- lung and gastrointestinal problems
- vision and hearing loss

LBW, and particularly VLBW infants:

- greater risk of death within the first month of life
- increased risk for developmental disabilities and chronic illness

**Criterion #5: Impetus for Change**

- L.B. 264 secondary prevention programs, e.g. home visitation bill
- Lincoln's Prenatal Home Visitation Coalition
- Early Head Start in select locations
- Omaha's Baby Blossoms collaborative
- Healthy Start in select locations
- Good Beginnings in select locations
- March of Dimes prematurity campaign

**Criterion #6: Large number of People Effected<sup>12</sup>**

- 1,800 LBW annually
- More than 300 VLBW annually
- The special care for 1,800 babies, plus a compounding impact on families, communities, school systems, with increasing demands on dwindling Medicaid funding, etc.

---

<sup>12</sup> Calculations were derived by multiplying approximately 26,000 Nebraska annual births by the percentages for LBW and VLBW.

## **Tobacco use during pregnancy and post-partum**

Tobacco use during pregnancy has been shown to be an important risk factor for low birth weight and other adverse birth outcomes. Infants exposed to environmental tobacco are at greater risk for SIDS and for respiratory illnesses. Cognitive and behavioral outcomes for infants may also be affected by postnatal exposure to tobacco smoke. According to Vital Statistics, 13.8% of Nebraska women smoke during pregnancy. NE PRAMS data shows even higher usage (14.8%). These rates are higher than the national rate of 11.4%, and the HP2010 Objective of 1%.

- The state rate for smoking postpartum is 21.4, which is statistically significantly higher than the national rate (20.8%). Source: NE PRAMS, CDC PNSS, 2002
- 46.2% of Native American women in Nebraska report currently smoking which is nearly twice the rate of the overall population of NE women (Source NE BRFSS), and 30.6% of pregnant Native American women report smoking, which is more than twice the rate for all NE pregnant women. (Source NE Vital Statistics)

### **Criterion #1: Effective Intervention**

- Good evidence that extended or augmented smoking cessation counseling (5-15 minutes) using messages and self-help materials tailored for pregnant smokers, compared with brief generic counseling interventions alone, substantially increases abstinence rates during pregnancy, and leads to increased birth weights. Although relapse rates are high in the post-partum period, reducing smoking during pregnancy is likely to have health benefits for both the baby and the expectant mother. (US Preventive Services Task Force, AHRQ 2003)

### **Criterion #2: Disproportionate Effects Among Subgroups of the Population**

- Native American women smoke (46.2%) at nearly 2x greater than the state rate for women
- Pregnant Native American women smoke more than 2x the state rate of pregnant smokers

### **Criterion #3: Problem is worse than the Benchmark or Increasing**

- Separate state rates for pregnant women who smoke (13.8% vital statistics) (14.8% PRAMS) are both worse than two benchmarks (national 11.4%) and (HP2010 1%)
- State rate for postpartum smokers (21.4%) is significantly higher than the US rate (20.8%)

### **Criterion #4: Severity of the Consequence**

- Tobacco use during pregnancy is a risk factor for LBW and other poor birth outcomes.
- Infants exposed to environmental tobacco are at greater risk for SIDS & respiratory illnesses.
- Cognitive/behavioral outcomes for infants may be affected by environmental tobacco smoke.

### **Criterion #5: Impetus for Change**

- Local and potential state smoking bans
- Insurance and employment policies favoring non-smokers
- Available resources are requested and distributed (anecdotal)

### **Criterion #6: Large number of People Effectuated<sup>13</sup>**

- ~3,500 Nebraska women smoke during pregnancy
- ~5,150 Nebraska women smoke postpartum (high incidence of relapse)

<sup>13</sup> Calculations were derived by multiplying approximately 26,000 Nebraska births annually by the percentages of prenatal and postpartum Nebraska women who smoke.

## **Infant mortality**

According to NE Vital Statistics, Nebraska's rate of infant mortality (5.4/1,000) is higher than the HP2010 Objective (4.5/1,000). Nebraska's African American rate (15.9/1000) is significantly higher than the state rate and is also higher than the United States rate for African Americans (14.1/1000). Access to care, prematurity, low birth weight, and safe sleep methods likely contribute to this higher rate of mortality.

- Nebraska's SIDS rate in 2003 was 92.7/100,000 live births, compared to the Healthy People 2010 objective of 25/100,000 and the U.S. rate of 57.1/100,000 (2002).
- For the period of 1995 – 2003, SIDS rates for African American infants have been consistently higher than the state rates

### **Criterion #1: Effective Intervention**

#### **Proven Interventions**

- See proven interventions for low birth weight and premature births
- Back sleeping campaign, along with other risk reduction practices.

#### **Promising Interventions**

- Focus on modifying behaviors, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness. (CDC, Office of Minority Health.)
- Healthy Start. (Promising Practices Network on Children, Families and Communities.)
- NICU collaborative quality improvement and selective referral to improve the quality of neonatal care. (AHRQ (HS 13371 and HS 10858))

### **Criterion #2: Disproportionate Effects Among Subgroups of the Population**

- African American infant mortality rate (15.9/1000) is significantly higher than state rate, and the national rate for African Americans (14.1/1000)
- African American SIDS rates are consistently higher than state rate (1995-2003)

### **Criterion #3: Problem is worse than the Benchmark or Increasing**

- Infant mortality state rate (5.4/1000) is higher than the benchmark (HP2010 4.5/1000)

### **Criterion #4: Severity of the Consequence**

- Death of infant
- Emotional distress of family unit
- Financial costs, e.g. hospitalization

### **Criterion #5: Impetus for Change**

- L.B. 264 secondary prevention programs, e.g. home visitation bill
- Omaha's Baby Blossoms collaborative
- Healthy Start in select areas
- March of Dimes

### **Criterion #6: Large number of People Effectuated**

141 Nebraska infants did not survive their 1<sup>st</sup> birthday. (Nebraska Vital Statistics, 2003)

## Birth outcomes for pregnant adolescents

Adolescent pregnancy is associated with higher rates of illness and death for both the mother and infant. Pregnant teens are at much higher risk of having serious medical complications such as toxemia, pregnancy-induced hypertension, significant anemia, premature delivery, and/or placenta previa. Infants born to teens are 2 to 6 times more likely to have low birth weight than those born to older mothers. In Nebraska, pregnant teens have particularly poor outcomes. According to Nebraska's 2003 Vital Records, adolescent pregnancies result in high rates of infant mortality.

- Fetal deaths occurred at a rate of 29.8 per 100,000 to teen moms age 15-19, compared to 7.5 nationally.
- Neonatal deaths occurred at a rate of 23.6 per 100,000 to teen moms age 15-19 compared to 6.3 nationally
- Infant deaths occurred at a rate of 33.0 per 100,000 compared to 10.3 nationally.

### Criterion #1: Effective Intervention

#### **Proven Interventions**

- See proven interventions for reducing premature births and low birth weight

#### **Promising Interventions**

- Comprehensive case managed services. Bowman and Palley, Journal of Health & Social Policy, 2004 Volume: 18 Issue 1
- School-based comprehensive adolescent pregnancy programs. Duggan and Devoe, J. Adolescent Health. 2003 Nov. 33(5):349-58

### Criterion #2: Disproportionate Effects Among Subgroups of the Population

Nebraska statistics show disproportionate effects for prematurity and LBW, both of which are associated with an increased risk of infant mortality.

- Infants born to teens are 2 - 6 x more likely have LBW than those born to older mothers.
- African American pregnant teens are more likely to give birth prematurely than the state rate, and the trend is increasing.
- African American and Asian teen moms are more likely to deliver LBW

### Criterion #3: Problem is worse than the Benchmark or Increasing

- State rates are much worse than the national rates in three birth outcomes to teen moms age 15-19

	State	National
▪ Fetal death	29.8 / 100,000	7.5 / 100,000
▪ Neonatal death	23.6 / 100,000	6.3 / 100,000
▪ Infant death	33.0 / 100,000	10.3 / 100,000

### Criterion #4: Severity of the Consequence

- Adolescent pregnancy is associated with higher rates of illness and death for both the mother and infant.
- Pregnant teens are at much higher risk of having serious medical complications such as toxemia, pregnancy-induced hypertension, significant anemia, premature delivery, and/or placenta previa.

- Babies born to teen moms are at increased risk for LBW and prematurity, resulting in serious health problems:
- medical complications
- long-term disabilities
- death

Very premature babies have the highest risk of death and lasting disabilities:

- mental retardation
- cerebral palsy
- lung and gastrointestinal problems
- vision and hearing loss

LBW, and particularly VLBW infants:

- greater risk of death within the first month of life
- increased risk for developmental disabilities and chronic illness

**Criterion #5: Impetus for Change**

- Student parent programs in public schools
- UNMC Maternal Care Program
- L.B. 264 secondary prevention programs, e.g. home visitation bill (child protection emphasis but with implications for improving pregnancy outcomes and infant health)
- Lincoln's Prenatal Home Visitation Coalition
- Early Head Start in select locations
- Omaha's Baby Blossoms collaborative
- Healthy Start in select locations
- Good Beginnings in select locations
- March of Dimes
- Cost-savings issues, e.g. ICUs, disability, LTC, special education, morbidity, quality of life
- Emerging social awareness

**Criterion #6: Large number of People Effected**

- 2,329 babies and their teen mothers.<sup>14</sup>
- affects family unit, often extended family members

---

<sup>14</sup> Nebraska Vital Statistics, 2003 teen births.

## **Breastfeeding initiation and duration**

Breastfeeding has been shown to have a number of health benefits for infants, including enhanced immune systems and resistance to infection, less unnecessary weight gain with less risk of being overweight later in life, and lower risk of developing chronic diseases. The 2003 National Immunization Survey included questions on breastfeeding. Nebraska's rate for ever breastfed was 72.7% and 35.3% for breastfeeding at 6 months. These rates are lower than the HP2010 objectives of 75% and 50% respectively.

- NE WIC infants ever breastfed was 63.1% and 22.4% for breastfed at 6 months (2003 WIC )

### **Criterion #1: Effective Intervention**

#### **Proven Interventions**

- Programs combining breastfeeding education with counseling increased rates of breastfeeding initiation and its continuation for up to 3 months. Ongoing support for patients increased the proportion of women continuing breastfeeding for up to 6 months. (U.S. Preventive Services task Force, AHRQ, 2003.)
- Baby-Friendly Hospital Initiative. (Best Practice Initiative, U.S. Department of Health and Human Services)

### **Criterion #2: Disproportionate Effects Among Subgroups of the Population**

- disproportionate effects between state and WIC data suggests socioeconomic differences

### **Criterion #3: Problem is worse than the Benchmark or Increasing**

- state rates are below the benchmark

	<u>State</u>	<u>NE WIC</u>	<u>Benchmark</u>
▪ ever breastfed	72.7%	63.1%	75%
▪ at 6 months	35.3%	22.4%	50%

### **Criterion #4: Severity of the Consequence**

- Breastfeeding has a number of health benefits for infants,
- enhanced immune systems and resistance to infection
- less unnecessary weight gain with less risk of being overweight later in life
- lower risk of developing chronic diseases.

### **Criterion #5: Impetus for Change**

- U.S. Surgeon General's Reports
- American Academy of Pediatricians (AAP)
- American College of Obstetricians and Gynecologists (ACOG)
- American Academy of Family Physicians (AAFP)
- American Public Health Association (APHA)
- L.B. 104 to allow breastfeeding in any public or private location

### **Criterion #6: Large number of People Effectuated**

26,000 potential Nebraska beneficiaries annually<sup>15</sup> Ongoing impact beyond infancy

<sup>15</sup> Approximation of Nebraska annual births.

## C. Children

### Overweight Children

#### *Reduce the rates of overweight children ages 1-9 in Nebraska.*

According to public health data, the trend has been increasing for children ages 1-9 who are at risk for overweight and obesity. Many of the health conditions resulting from being overweight are beginning to appear in youth such as high blood pressure, elevated cholesterol and type 2 diabetes. Overweight children are also susceptible to psychosocial problems that include depression and low self-esteem, which can impair academic and social functioning.

#### *Criterion 1: An Effective Intervention is Available*

- The Institute of Medicine recommends broad-based approaches of promising practices

FEDERAL GOVERNMENT
<ul style="list-style-type: none"> <li>Establish an interdepartmental task force and coordinate federal actions</li> <li>Develop nutrition standards for foods and beverages sold in schools</li> <li>Fund state-based nutrition and physical-activity grants with strong evaluation components</li> <li>Develop guidelines regarding advertising and marketing to children and youth by convening a national conference</li> <li>Expand funding for prevention intervention research, experimental behavioral research, and community-based population research; strengthen support for surveillance, monitoring, and evaluation efforts</li> </ul>
INDUSTRY AND MEDIA
<ul style="list-style-type: none"> <li>Develop healthier food and beverage product and packaging innovations</li> <li>Expand consumer nutrition information</li> <li>Provide clear and consistent media messages</li> </ul>
STATE AND LOCAL GOVERNMENTS
<ul style="list-style-type: none"> <li>Expand and promote opportunities for physical activity in the community through changes to ordinances, capital improvement programs, and other planning practices</li> <li>Work with communities to support partnerships and networks that expand the availability of and access to healthful foods</li> </ul>
HEALTH-CARE PROFESSIONALS
<ul style="list-style-type: none"> <li>Routinely track body mass index (BMI) in children and youth and offer appropriate counseling and guidance to children and their families</li> </ul>
COMMUNITY AND NONPROFIT ORGANIZATIONS
<ul style="list-style-type: none"> <li>Provide opportunities for healthful eating and physical activity in existing and new community programs, particularly for high-risk populations</li> </ul>
STATE AND LOCAL EDUCATION AUTHORITIES AND SCHOOLS
<ul style="list-style-type: none"> <li>Improve the nutritional quality of foods and beverages served and sold in schools and as part of school-related activities</li> <li>Increase opportunities for frequent, more intensive, and engaging physical activity during and after school</li> <li>Implement school-based interventions to reduce children's screen time</li> <li>Develop, implement, and evaluate innovative pilot programs for both staffing and teaching about wellness, healthful eating, and physical activity</li> </ul>
PARENTS AND FAMILIES
<ul style="list-style-type: none"> <li>Engage in and promote more healthful dietary intakes and active lifestyles (e.g., increased physical activity, reduced television and other screen time, more healthful dietary behaviors)</li> </ul>

Source: Institute of Medicine Fact Sheet, Childhood Obesity in the United States: Facts and Figures, September 2004

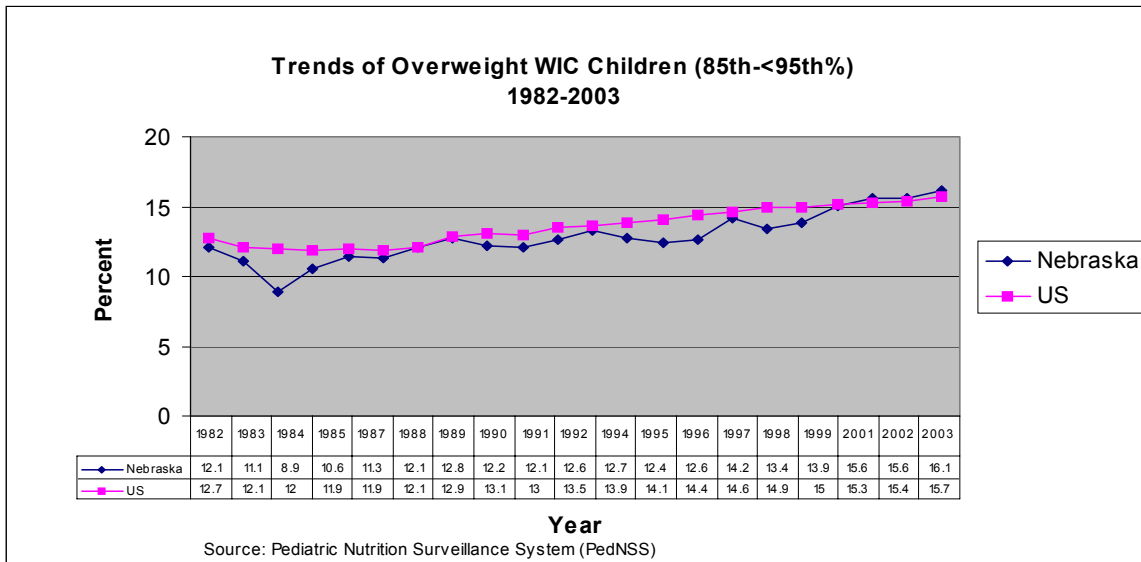
#### *Criterion 2: Disproportionate Effects Among Subgroups of the Population*

- In Nebraska, more Native American children K-12 (27.9%) and Hispanic children K-12 (25.3%) are overweight compared to for White children K-12 (15.1%).

Source: Nebraska Cardiovascular Health Program

**Criterion 3: Problem is Worse than the Benchmark or Increasing**

- Nebraska's rate of overweight/risk of overweight is greater than the Healthy People 2010 objectives for four indicators:
  - The percent of Nebraska WIC children 1-4 years who are overweight (>95% weight/age) is significantly higher than HP2010 (14.9% vs. 5%) and increasing.
  - The percent of Nebraska WIC children 2-4 years who are at risk for overweight (>85%&<95% weight/age) is higher than HP2010 (16.1% vs. 5%) and increasing.
  - The percent of Nebraska WIC children 2-4 years who are overweight (>95% weight/age) is significantly higher than HP2010 (13.4% vs. 5%) and increasing.
  - The percent of Nebraska school children in grades K-4 who are at risk for overweight (>85%&<95% weight/age) is significantly higher than HP2010 (16.7% vs. 10%).



**Criterion 4: Severity of Consequences**

**Physical, Social, and Emotional Health Consequences of Obesity in Children and Youth**

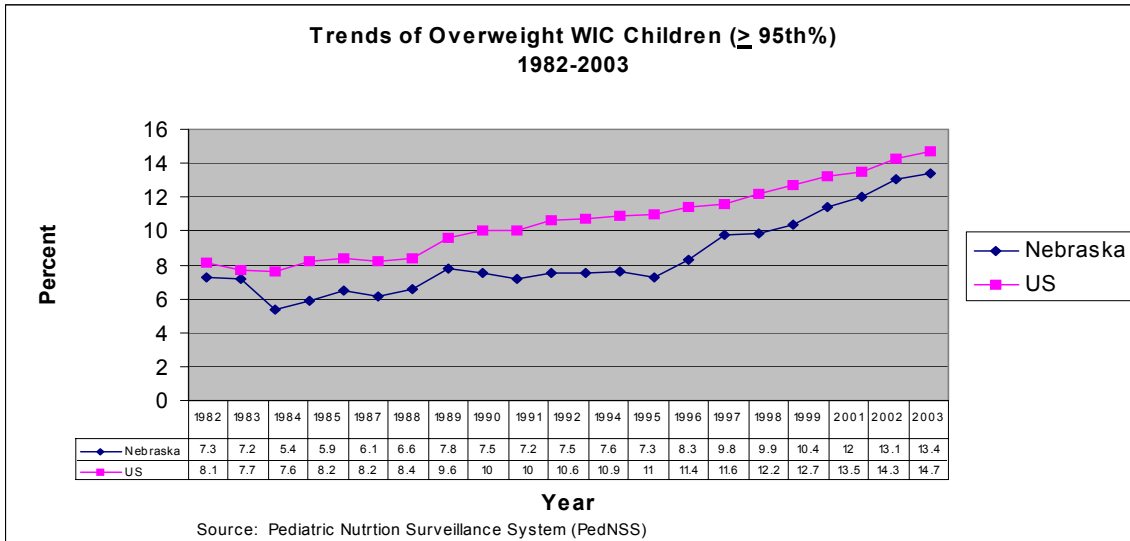
**Physical Health**

- Glucose intolerance and insulin resistance
- Type 2 diabetes
- Hypertension
- Dyslipidemia
- Hepatic steatosis
- Cholelithiasis
- Sleep apnea
- Menstrual abnormalities
- Impaired balance
- Orthopedic problems

**Emotional Health**

- Low self-esteem
- Negative body image

- Depression



### Social Health

- Stigma
- Negative stereotyping
- Discrimination
- Teasing and bullying
- Social marginalization

Source: Overview of the IOM's Childhood Obesity Prevention Study

### *Criterion 5: There is Impetus for Change*

- Bills introduced in the Nebraska legislature during the current session:
  - The Nutrition in Schools Act (LB 285) limits student access to vending machines
  - The Physical Education in Schools Act (LB 681) requires minimum amount of physical education classes during the week.
- Action for Healthy Kids, All Recreate Fridays, N-Lighten Programs, National Association of Health, Physical Education, Recreation and Dance (NAHPERD).
- Public Law 108-265 amended the Child Nutrition Act of 1966 to include:
  - A local school wellness policy for schools participating in programs under the National School Lunch Act or Child Nutrition Act.
  - Physical activity in the definition of nutrition education for the WIC Program.
- According to a 2005 article released by Child Magazine at [www.child.com](http://www.child.com), Nebraska is ranked 49/50 in making children's nutrition and physical education a top priority.

### *Criterion 6: Large Number of People Affected*

- In 2003, 13.4% percent of WIC children 2-4 years were overweight and 16.1% WIC children 2-4 years were at risk for overweight. These trends have increased significantly from 7.6% (overweight) and 12.7% at (risk for overweight) in 1994. Source: Nebraska PedNSS
- In 2003, 16.7% children in grades K-4 are at risk for overweight and 14.9% are overweight. Source: Overweight Among Nebraska Youth Report, Nebraska Cardiovascular Health Program
- In 2004, 2.41% Head Start and Early Head Start children received, or were receiving medical treatment for overweight. Source: Nebraska Head Start Report 2001-2004 Program Years

## **Unintentional Injuries**

### ***Reduce the number of deaths and hospitalizations due to unintentional injuries for Nebraska children ages 1-9.***

According to Nebraska Vital Statistics & Hospital Discharge data, unintentional injuries are the leading cause of death and hospitalizations among children 1-9. Unintentional injuries are preventable. They may lead to premature death, lifelong disabilities, and create a financial burden on our health care system in direct medical care and rehabilitation costs.

#### ***Criterion 1: An Effective Intervention is Available***

- According to the National SAFE KIDS program, injury deaths have declined by 40% since its inception in 1987.
- There are many separate influences going on simultaneously that account for the declines. Effective interventions include implementing child safety laws (child restraint use, bike helmet use), public education (heightened awareness of car seat use, dangers of baby walkers), and environmental changes (distributing smoke alarms, bike helmets, addition of straps on child products).
- Bike helmets are the single most effective safety devices to reduce head injury and deaths from bike related incidences.
- Smoke alarms cuts the chances of dying in a residential fire nearly in half.

#### ***Criterion 2: Disproportionate Effects Among Subgroups of the Population***

- In Nebraska, Native American children 1-9 years are 2 times as likely and Hispanic children 1-9 years 1.5 times as likely to die from unintentional injuries compared to the overall population 1-9 years.  
Source: CDC WISQARS
- Nationally, unintentional injuries disproportionately affect poor children compared to those with greater socioeconomic resources.  
Source: National SAFE KIDS
- Nationally, children ages 4 and under are at a greater risk of unintentional injury accounting for 49 percent of the deaths.  
Source: National SAFE KIDS
- Nationally, children living in rural areas are at greater risk from unintentional injury-related deaths than children in urban areas.  
Source: National SAFE KIDS

#### ***Criterion 3: Problem is Worse than the Benchmark or Increasing***

- In 2002, Nebraska's rate of fatalities due to unintentional injuries (including motor vehicle crashes) was 10.8 per 100,000 children ages 1-9 compared to 7.9 nationally.  
Source: CDC WISQARS
- Childhood mortality rates for unintentional injuries in Nebraska have stayed relatively the same over the years.
- When Nebraska's unintentional injury mortality rate is compared with HP2010 we are still above the objective.
- The unintentional injury death rate for children ages 1-4, in Nebraska, is 30.9 compared to the HP2010 which is at 18.6.
- For Nebraska children ages 5-9, the unintentional injury death rate is 20.3 compared to HP2010 objective at 12.3.

***Criterion 4: Severity of Consequences***

- The leading cause of death for children 1-9 years is motor vehicle crashes (48.1%).  
Source: CDC WISQARS 1999-2002
- For every child injured, the total cost is more than \$12,700, which includes medical costs, future earnings lost and quality of life.
- Every dollar spent on a child safety seat saves \$32 in direct medical costs.
- Every dollar spent on a bike helmet saves \$30 in direct medical costs.
- Every dollar spent on a smoke alarm saves \$69 in fire-related costs.

***Criterion 5: There is Impetus for Change***

- Two Nebraska laws have been implemented in the past two years:
  - All children up to age 6 years are to be properly secured in a federally approved child passenger restraint system while riding in a motor vehicle.
  - Children up to age eighteen are prohibited from riding the back of pickup trucks.
- Some Nebraska communities have implemented local ordinances (e.g., motorized scooters).
- Local community support (policy makers, hospital CEO's, mayors and parent groups).
- Motor vehicle safety - child safety seat checks.

***Criterion 6: Large Number of People Affected***

- In 2003, 10,446 children ages 1-9 were hospitalized due to an unintentional injury.  
Source: Nebraska Hospital Discharge data

## **Abuse/Neglect/Intentional Injuries**

### **Reduce the number and rates of abuse, neglect and intentional injuries among Nebraska children age 1-9.**

According to the *2004 KIDS Count Report*, the number of substantiated cases of child abuse/neglect has increased by 18% (369 cases) since 1999. Violence can disrupt growth and development, lower self-esteem, perpetuate a cycle of violence and cause or exacerbate mental health problems.

#### ***Criterion 1: An Effective Intervention is Available***

##### **Proven Interventions**

- Early childhood home visitation programs in which parents and children are visited in their home during the child's first 2 years of life by trained personnel who provide some combination of the following: information, support, or training regarding child health, development, and care.  
Source: CDC MMWR 2003; 52(No. RR-14): 1-9
- Family Connections, a psychosocial early intervention program including emergency assistance, family assistance and social support.  
Source: Children's Bureau, Office on Child Abuse and Neglect, US HHS, "Emerging Practices in the Prevention of Child Abuse and Neglect," 2003
- Parent focused interventions with well-specified training components aimed at improving child rearing competence and stress management has been supported by empirical findings as effective measures for reducing risk factors associated with physical child abuse.  
Source: Cohn Donnelly, A. An Approach to Preventing Child Abuse. Chicago, IL

##### **Promising Interventions**

- Includes parent education, school based-programs for prevention of child sexual abuse, and respite services. Source: Ibid
- Early and regular child and family screening and treatment to detect and treat health and developmental problems early and to detect problem children may be having, including abuse and neglect. Source: Cohn Donnelly, A. An Approach to Preventing Child Abuse.

#### ***Criterion 2: Disproportionate Effects Among Subgroups of the Population***

- For the years 2000-2003, Native American children (9.8) and African American children (6.9) in Nebraska had higher rates of homicide per 100,000 than the overall population (1.4). The numbers, however, are small, 9 total deaths for 2000-2003.  
Source: CDC WISQARS 2002
- Nationally, non-Hispanic black and American Indian or Alaskan Native children are over represented among victims of child maltreatment.  
Source: Child Trends Data Bank, [www.childtrendsdatabank.org](http://www.childtrendsdatabank.org)
- The causes of child maltreatment are more common in poor and extremely poor families than in families with higher incomes. Source: National Research Council, Understanding Child Abuse and Neglect. Washington, DC: National Academy Press, 1993
- In Nebraska, data shows that substantiated cases of child abuse and neglect are more likely to involve young children. In 2003, 64% of the children involved in substantiated cases were ages 0-8. The average age of a child in a substantiated case was seven years old.  
Source: Kids Count Report, 2004
- Nationally, younger children are also more likely than older children to experience abuse and neglect. In 2002, children ages three and under had a reported child maltreatment rate of 16.0

per 1,000, compared with 6.0 per 1,000 for children ages 16 to 17. Source: Child Trends Data Bank, [www.childtrendsdatabank.org](http://www.childtrendsdatabank.org)

***Criterion 3: Problem is Worse than the Benchmark or Increasing***

- The total number of child neglect or abuse reports that are received by Child Protective Services (CPS) has significantly increased. For children ages 1-9, this number increased by nearly 5,000 reports (58.6%) between 1999 & 2003. Nebraska's rate was 61.2 reports received per 1,000 children in 2003 up from 38.7 per 1,000 in 1999. Source: Nebraska Child Protective Services
- The number of child neglect or abuse reports that were substantiated by Child Protective Services (CPS) has significantly increased. This number increased by approximately 750 more between 1999 & 2003. Nebraska's rate was 14.9 substantiated reports per 1,000 children in 2003, up from 11.4 per 1,000 in 1999. Source: Nebraska Child Protective Services
- The total number of children involved in substantiated reports of abuse or neglect has also significantly increased. This number increased by approximately 350 more children between 1999 & 2003. In Nebraska in 2003, over 2,000 children ages 1-9 (9.7 per 1,000). Source: Nebraska Child Protective Services

***Criterion 4: Severity of Consequences***

- Child abuse is linked to an increased risk of substance abuse in later life.
- Child abuse and neglect can lead to death. In 2002, approximately 1,400 children nationally died as the result of abuse or neglect. Source: Child Trends Data Bank.
- It is estimated that more than \$24 billion is spent each year in the United States on direct costs associated with child abuse/neglect including expenses related to hospitalization, chronic health problems, child welfare system, law enforcement and the judicial system.
- It is estimated that more than \$94 billion is spent each year in the United States on indirect costs associated with child abuse/neglect including expenses related to special education, mental health and health care, juvenile delinquency, lost productivity to society and adult criminality. Source: Prevent Child Abuse America –Edna McConnell Clark Foundation

***Criterion 5: There is Impetus for Change***

- Governor's Children's Task Force
- Legislation has been introduced and passed in recent years pertaining to child welfare.
- During this current session, LB 264 has been introduced. This legislative bill affirms home visitation as effective prevention, as well as resulting in an actual reduction of incidents of child abuse and neglect for at-risk children in Nebraska.
- Child Death Review Team
- Systems advocacy (e.g., Foster Care Review Board, Voices for Children)
- Child abuse hotline - standardized reporting process.
- Nebraska Child Abuse Prevention Fund Board (July, 2004, granted \$207,355 to 17 community programs to increase awareness of child abuse and neglect and to provide prevention activities in local communities.
- Nebraska Fatherhood Initiative (e.g., UNL, UNO, UNMC, HHSS).
- Prevent Child Abuse Nebraska

***Criterion 6: Large Number of People Affected***

- In Nebraska 2003, 58% of Nebraska children in substantiated cases of abuse and neglect involved children 1-9, over 2,000 children. Source: Nebraska Children Protective Services
- Three million cases of suspected child abuse and neglect are reported each year in the U.S.

## Secondhand Smoke

### **Reduce the number of Nebraska children ages 1-9 exposed to secondhand smoke.**

According to *Data and Trends on Tobacco Use in Nebraska*, 1 in 4 Nebraska households have children aged 0-12 exposed to household tobacco smoke. Secondhand smoke has a harmful effect on the respiratory health of children. Because their lungs are not fully developed, young children are particularly susceptible to secondhand smoke. Exposure to secondhand smoke is associated with an increased risk for sudden infant death syndrome (SIDS), asthma, bronchitis, and pneumonia in young children.

#### ***Criterion 1: An Effective Intervention is Available***

The Institute of Medicine: Growing Up Tobacco Free states that

- Tobacco-free policies should be adopted in all public locations.
- Studies conducted in individual workplaces have found that smoke-free workplaces have been effective in reducing nonsmokers' exposure to secondhand smoke.
- Studies of smoking behavior in smoke-free settings observed decreases in daily tobacco use.
- Optimal protection of nonsmokers and smokers requires a smoke-free environment.
- The most effective strategies used comprehensive, multicomponent approaches to implement policies banning smoking within communities.
- Less comprehensive strategies, such as posted warnings and educational material, had only a moderate effect.

Source: *Growing Up Tobacco-Free: Preventing Nicotine Addiction in Children and Youths*, the Institute of Medicine (IOM) at the National Academy of Sciences, September 13, 1994

#### ***Criterion 2: Disproportionate Effects Among Subgroups of the Population***

- Children appear to suffer disproportionately from the effects of second tobacco smoke. Children's exposure to secondhand smoke is responsible for: (1) increases in the number of asthma attacks and severity of symptoms in 200,000 to 1 million children with asthma; (2) between 150,000 and 300,000 lower respiratory tract infections (for children under 18 months of age); and, (3) respiratory tract infections resulting in 7,500 to 15,000.

Source: The Environmental Protection Agency's web site: <http://www.epa.gov/smokefree/>

#### ***Criterion 3: Problem is Worse than the Benchmark or Increasing***

- The percent of Nebraska households with children < 5 years exposed to tobacco smoke is higher than the US average (24.0% vs. 19%)  
Source: Nebraska data from 1998-2000 BRFSS, US data from Survey on Radon Awareness and Environmental Tobacco Issues, US Environmental Protection Agency (EPA)
- The percent of Nebraska children < 5 years who have been exposed to tobacco smoke in their home is higher than the HP2010 objective (15.8% vs. 10%)  
Source: Nebraska data from *Data Trends on Tobacco Use in Nebraska, May 2004*. US data from the 1998 National Health Interview Survey
- The percent of Nebraska children 5-12 years who have been exposed to tobacco smoke in their home is higher than the US average (28.0% vs. 18%)  
Source: Nebraska data from *Data Trends on Tobacco Use in Nebraska, May 2004*. US data from 1999-2000 NHANES
- In 2004, 30% of 1-4 year olds enrolled in WIC resided in a household where someone smokes. Source: Nebraska WIC Program data

***Criterion 4: Severity of Consequences***

- Exposure to secondhand smoke is associated with an increased risk for sudden infant death syndrome (SIDS), asthma, bronchitis, and pneumonia in young children.
- Nationwide, secondhand smoke exposure is associated with 8,000 - 26,000 new asthma cases in children each year. Source: CDC

***Criterion 5: There is Impetus for Change***

- State Law was passed in 2004 making all licensed child care homes smoke free during the time one or more children are present in any part of the home.
- Bills introduced in the Nebraska legislature during the current session and are currently in general file:
  - Eliminates smoking in all childcare sites that are licensed by the State of Nebraska and in all licensed foster care homes only during times one or more foster children under the age of one-year-old are placed.
  - Eliminate all smoking/tobacco products on all school campus's including sports fields excluding college campuses.
- Lincoln voters have passed a 100% smoke free policy making the city the first Nebraska city to have 100% smoke free worksites.
- Other communities in Nebraska are working towards smoke free worksites.
- Education/awareness continues by Tobacco Free Coalitions across the State to increase the number of households that report their home to be smoke free.
- Education to parents to talk to children about tobacco use by the age of 5 or 6 and continue through their high school years.
- Parents are the greatest influence in their kids' lives. Even if parents smoke, talking to their children about the risks of tobacco use is essential.
- Education/awareness continues in order to provide all Recreation Centers, Parks and all public areas that children have access to, to be tobacco free.

***Criterion 6: Large Number of People Affected***

- 1 in 4 Nebraska households have children under 12 exposed to household tobacco smoke. Source: *Data Trends on Tobacco Use in Nebraska, May 2004*
- In 2003, for 20.2% of Nebraska households in which children age 17 or younger reside, smoking was allowed in some rooms or there were no restrictions on smoking anywhere in the house. Source: Nebraska 2003 BRFSS

## Oral Health Care

### **Increase access to quality oral health care for Nebraska children ages 1-9.**

According to the Office of Rural Health data, 58% (54/93) of Nebraska's counties have a shortage of dental health professionals, putting Nebraska's children in these counties at risk for poor oral health outcomes. Children need healthy teeth to eat nutritious foods to develop normally. Early tooth loss caused by dental decay can result in impaired speech development, failure to thrive, absence from and inability to concentrate in school, and reduced self-esteem.

#### ***Criterion 1: An Effective Intervention is Available***

##### **Proven Interventions**

- Community water fluoridation.  
Source: ASTDD Best Practices for State and Community Oral Health Programs, CDC MMWR 2001.
- Dental sealants are effective both in preventing tooth decay.  
Source: Siegal MD. 1995. Workshop on Guidelines for Sealant Use. *Journal of Public Health Dentistry* 55(5): 257-320.
- School-based dental sealant programs.  
Source: ASTDD Best Practices for State and Community Oral Health Programs, CDC MMWR 2001;
- Professional interventions begin at approximately 12 months of age.  
Source: Nowak FJ. 1997. Rationale for the timing of the first oral evaluation. *Pediatric Dentistry* 19(1): 8-11.
- School-based fluoride mouth rinse and supplement programs.  
Source: ASTDD Best Practices for State and Community Oral Health Programs

##### **Promising Practice**

- Fluoride tooth pastes, varnishes, mouth rinses, gels, and dietary supplements can also help prevent caries.  
Source: National MCH Oral Health Resource Center Fact Sheet

#### ***Criterion 2: Disproportionate Effects Among Subgroups of the Population***

- Nationally, as few as 3 percent of children from families with low incomes have dental sealants, compared with the national average for children of 23 percent.  
Source: US HP2010
- Nationally, the level of untreated dental caries among African American children aged 6 to 8 years (36%) and Hispanic children (43%) is greater than for white children (26%).  
Source: US HP2010
- For children ages 2 to 5, 75 percent of Early Childhood Caries (ECC) is found in 8 percent of the US population.  
Source: National MCH Oral Health Resource Center Fact Sheet
- National data indicate that 80% of the dental carries in the permanent teeth of children is concentrated in 25% of the child & adolescent population (due to income, racial & ethnic groups, and parents with lower levels of education). Source: Nebraska 2010 Goals & Objectives

#### ***Criterion 3: Problem is Worse than the Benchmark or Increasing***

- Nationally, the proportion of untreated dental caries in permanent dentition of school-aged children has been declining overall but has increased in the primary dentition among children aged 6 to 8 years. Source: US HP2010
- The percentage of US school-aged children with dental sealants has risen in recent years, however, no increase has occurred among children in low-income populations. Source: US HP2010
- In Nebraska, 70 percent of the population served by community water systems receive drinking water with optimal levels of fluoride.  
Source: Nebraska 2010 Goals & Objectives

***Criterion 4: Severity of Consequences***

- An estimated 51 million school hours are lost each year to dental-related illness.  
Source: National Call to Action to Promote Oral Health - National Institutes of Health 2003
- Twenty-three million children are without dental insurance coverage. Uninsured children are 2.5 times less likely than insured children to receive dental care.  
Source: Children's Dental Health Needs and School-Based Services: A Fact Sheet, CDC
- In 1999 the average cost of applying one dental sealant was \$27.00, compared with the average cost of \$73.77 for filling one cavity.  
Source: American Dental Association. 2000. *1999 Survey of Dental Fees*. Chicago, IL: American Dental Association Survey Center.
- ECC has significant financial consequences. Many children with ECC require restorative treatment in an operating room under general anesthesia. State Medicaid expenditures for restorative dental care delivered under general anesthesia range from \$1,500 to \$2,000 per child per year.  
Source: National MCH Oral Health Resource Center Fact Sheet

***Criterion 5: There is Impetus for Change***

- Statewide interest in interventions (e.g., telehealth)
- LB 158 was introduced this session and would require water fluoridation in communities with a population over 1,000.
- Local health districts have conducted oral health needs assessments (e.g., Elkhorn Logan Valley Public Health Dept. and Loup Basic Public Health Dept.)
- Child advocacy groups recognize oral health as an important health issue.

***Criterion 6: Large Number of People Affected***

- Dental caries (tooth decay) is the single most common chronic childhood disease - 5 times more common than asthma and 7 times more common than hay fever.  
Source: National Call to Action to Promote Oral Health - National Institutes of Health 2003
- 87% (81/93) Nebraska counties are state-designated oral health shortage areas for pediatric dentistry & oral surgery.  
Source: HHSS, Office of Rural Health
- 31.1% of Nebraska practicing dentists plan to retire by 2009.  
Source: Nebraska Dental Association Workforce Study, 2001
- According to Medicaid data, 26,197 (47.5%) of eligible children statewide receive preventative dental services.  
Source: HHSS/ Medicaid/EPSTD

## **D. Youth**

### **Nutrition and Physical Activity**

**Reduce the number of Nebraska youth who are at risk for being overweight or are overweight and increase youth participation in sufficient physical activity.**

- The most common causes of disability, disease and premature death result from individual choices and behaviors often formed during adolescence. Poor diet and lack of exercise developed during adolescence can lead to a substantial increase in the adult risk for coronary heart disease, type 2 diabetes, high blood pressure, some forms of cancer and certain musculoskeletal disorders such as osteoarthritis.
- Overweight and obese individuals also may suffer from social stigmatization, discrimination, and poor body image. Physical activity has numerous health benefits including less disease, healthier bones, muscles, and joints, better weight control and less anxiety and depression.

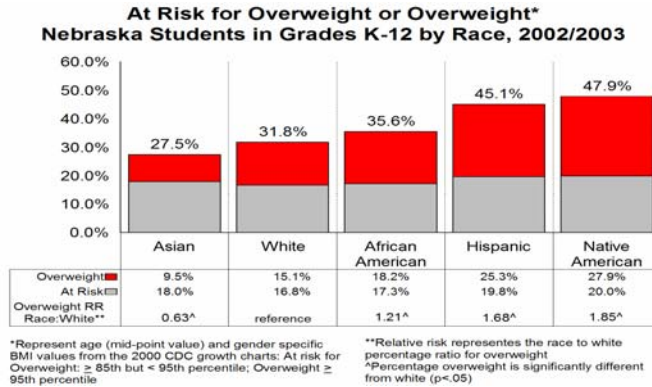
#### **An Effective Intervention is Available:**

Overweight and obesity must be approached as preventable and treatable problems with realistic and exciting opportunities to improve health and save lives.” –Surgeon General of the United States, 2001

- Comprehensive school health programs (CD –DASH)
- Healthcare providers plot BMI once a year (American Academy of Pediatrics)
- Limit sedentary behavior to 2 hours daily. (American Academy of Pediatrics)
- Enforce existing U.S. Department of Agriculture regulations that prohibit serving foods of minimal nutritional value. (IOM)
- Provide healthy vending machine choices in schools (IOM)
- Increase school sports participation (CDC-DASH)
- Community-wide mobilization (CDC-DASH)
  - Provide physical and social environments that encourage and enable safe and enjoyable physical activity, i.e. walking and biking opportunities. (CDC-DASH)

#### **Disproportionate Effects Among Subgroups of the Population: In Nebraska:**

- Close to half of Native American and Hispanic students are either at risk for overweight or overweight, 47.9% and 45.1% respectively.
- African American students are 20.5 percent more likely than White students to be overweight, 18.2 and 15.1% respectively. Source: NE HHS Cardiovascular Health Program



**Problem is Worse than the Benchmark or Increasing:**

- Thirty-four percent of students in grades 5-12 are at risk for or overweight ( $> 85\%$  BMI) compared to 28.9% in the U.S. The **Healthy People 2010** Objective for this age group is 5%. Source: NE HHS Cardiovascular Health Program
- Sixty-one percent of the Nebraska students ate two or fewer servings of fruits and vegetables per day, less than 1 in 5 (18%) students consume milk regularly (an average of three or more glasses per day), and 51% drank 12 or more ounces of soda or pop daily during the past 7 days (24% of students drank 32 or more ounces of soda per day during the past seven days). Source: 2003 YRBS data, NE Cardiovascular Health Program

Nutrition among Nebraska High School Students, 2003								
	5-a-day		Regular Milk Consumption		Regular Soda Consumption		Excessive Soda Consumption	
	n*	%**	n*	%**	n*	%**	n*	%**
Overall	2,750	16.3%	2,888	18.4%	2,558	50.7%	2,558	23.8%
Gender								
Female	1,389	14.3%	1,447	12.6%	1,293	42.8%	1,293	17.7%
Male	1,359	18.3%	1,439	24.0%	1,263	58.5%	1,263	29.7%
Grade								
9th	589	17.1%	625	22.4%	570	48.7%	570	21.9%
10th	803	18.8%	842	19.2%	751	46.1%	751	21.7%
11th	689	12.7%	721	16.0%	634	53.0%	634	26.2%
12th	660	16.6%	691	15.5%	595	55.3%	595	26.0%

\*Non-weighted sample size value  
\*\*Weighted percentage  
Note: see indicator definitions under the appropriate sub-headings within this chapter for further detail  
Source: 2003 Nebraska Youth Risk Behavior Survey

- Thirty-three percent of students attended PE classes daily and exercised for more than 20 minutes. Sixty-five percent engaged in vigorous physical activity for at least 20 minutes on 3 or more of the last 7 days. The **Healthy People 2010** Objective for vigorous physical activity for this age group is 85%. Source: 2003 YRBS data

Physical Activity among Nebraska High School Students, 2003														
	Sufficient Moderate PA		Sufficient Vigorous PA		Regular Strengthening Exercise		Sufficient PA in all its forms		Insufficient PA		Regular Sports Team Participation		Quality Daily PE Class	
	n*	%**	n*	%**	n*	%**	n*	%**	n*	%**	n*	%**	n*	%**
Overall	2,879	26.7%	2,882	64.7%	2,896	53.6%	2,852	19.2%	2,859	32.0%	2,751	41.9%	2,540	33.3%
Gender														
Female	1,436	23.7%	1,439	59.7%	1,444	46.5%	1,424	15.5%	1,428	36.4%	1,378	35.2%	1,283	27.6%
Male	1,441	29.6%	1,441	69.3%	1,450	60.3%	1,426	22.7%	1,429	27.7%	1,371	48.2%	1,256	38.9%
Grade														
9th	619	28.2%	620	71.0%	625	59.7%	612	22.3%	613	25.9%	594	48.2%	537	43.4%
10th	843	29.0%	841	66.9%	846	54.1%	833	20.6%	835	29.0%	808	42.2%	759	33.5%
11th	722	24.0%	724	63.0%	724	52.9%	717	17.2%	720	33.4%	704	38.0%	637	24.5%
12th	686	25.5%	688	57.1%	692	47.5%	681	16.6%	682	40.0%	637	38.3%	600	31.3%
*Non-weighted sample size value														
**Weighted percentage														
Note: see indicator definitions under the appropriate sub-headings within this chapter for further detail														
Source: 2003 Nebraska Youth Risk Behavior Survey														

## Severity of Consequences:

### Physical Health

Glucose intolerance, Type 2 Diabetes, Hypertension, dyslipidemia, Gall bladder disease, sleep apnea, menstrual abnormalities, impaired balance, orthopedic problems, osteoarthritis

### Emotional Health

Low self-esteem, Poor body image, depression, and anxiety

### Social Health

Stigma, negative stereotyping, discrimination, teasing and bullying, and social marginalization Source: Overview of the IOM's childhood Obesity Prevention Study

## There is Impetus for Change:

- Governor's Council on Health Promotion and Physical Fitness
- Recognized as a problem by the community
- Several bills before current state legislative session addressing nutrition and P.A. ,
  - LB 285-Nutrition in Schools Act
  - LB 681 – Physical Education in Schools Act

## Large Number of People Affected:

- In the U.S., between 1976-1980 and 1999-2000, the percentage of overweight adolescents (age 12-19) more than tripled (increasing 210%). Source: CDC
- Approximately 32,000 Nebraska students (32.0%) in grades 9-12 do not engage in a sufficient amount of physical activity either moderate or vigorous. Source: 2003 YRBS

During an average school day, Nebraska's nearly 100,000 high school students spend an average of more than 3 ½ hours (3.65 hours) engaged in electronic sedentary behaviors, including television, video game system use, and computer use (excluding homework).

Source: 2003 YRBS

## **Unintentional Injury**

Reduce the number of unintentional injuries in youth 10-19 years of age. Unintentional injuries are the leading cause of death with significant racial/ethnic disparities.

Injuries are a leading cause of death for Americans of all ages, regardless of gender, race, or economic status.

- **Youth are at increased risk for unintentional injuries.**
- **Youth have a greater tendency to act impulsively and engage in risk-taking behaviors.**
- **Use of alcohol is a significant factor in unintentional injury among youth.**

### **Effective Intervention is Available:**

Injuries, unlike accidents, do not happen “by chance” and can be prevented. Some examples of effective interventions are:

- Limit unsupervised teenage passengers in automobiles. Teens driving alone are safer than in groups. The more teen passengers, the greater the risk.
- Graduated driver’s licensing
- Primary safety belt laws.
- Increase use of safety belts, motorcycle helmets, smoke alarms, and sports-related protective gear.
- School-based comprehensive injury prevention education.
- Education Campaigns/ Mass media campaigns
- Lower Blood Alcohol Concentration laws for inexperienced and young drivers

### **Disproportionate Effects Among Subgroups of the Population:**

Between 2000-2002 Nebraska Native American youth were almost 3 times more likely of dying in motor vehicle accidents than White youth. (62.3 vs. 19.6 per 100,000)

Nebraska Native American youth were 2 ½ times more likely of dying from unintentional injuries than White, youth. (62.3 vs. 23.8 per 100,000) Source: CDC WISQARS

### **Problem is Worse than the Benchmark or Increasing:**

Nebraska’s youth are at greater risk for unintentional injuries with rates higher than those for the U.S. Rates for unintentional injuries within this age group are increasing.

- In 2002, Nebraska’s unintentional injury death rate per 100,000 youth age 10-19 was **28.1**. This is higher than the U.S. rate of **20.9** for the same population. Source: NE Vital Statistics and CDC WISQARS
- Percentage of Nebraska students grades 9-12 that never use a safety belt is higher than the national rate (21.9% vs. 18.2%). The **Healthy People 2010** objective is to increase seatbelt use to **92%** of the youth population. Source: 2003 YRBS
- Percentage of Nebraska students grades 9-12 who drove a car after drinking alcohol is higher than U.S. rate (**20.9% vs. 12.1%**). Source: 2003 YRBS

- Percentage of Nebraska students grades 9-12 that rode with a drinking driver during the previous 30 days is higher than the U.S. rate (**38.5% vs. 30.2%**). The **Healthy People 2010** objective is **30%**. Source: 2003 YRBS

#### Severity of Consequences:

Death

Permanent disability

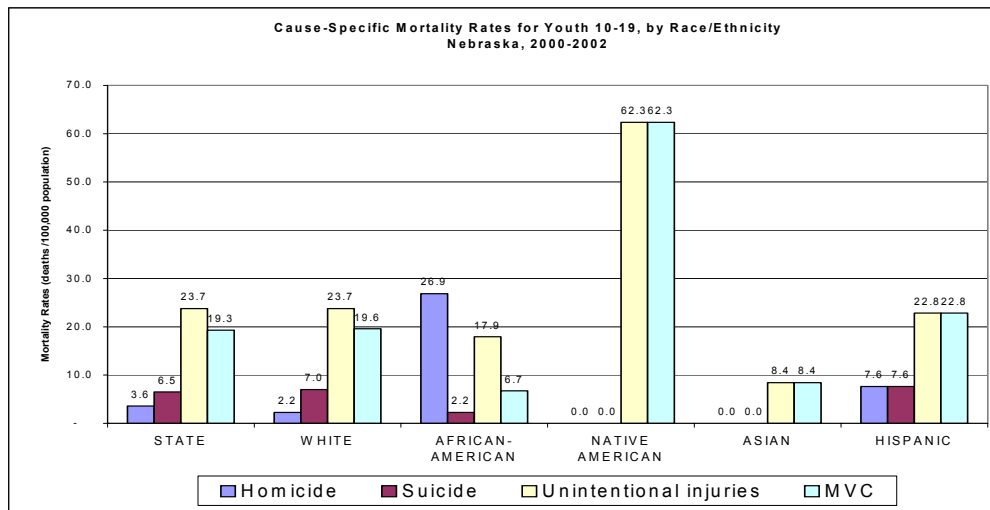
Chronic pain

#### There is Impetus for Change:

- Recognized as a problem by the community and policy makers
- Change in driver's licensing laws

#### Large Number of People Affected:

- In 2002, unintentional injury (73 deaths) was the leading cause of death among the 259,000 Nebraska youth ages 10-19 with marked racial and ethnic disparities.
- In 2002, Motor vehicle accidents among Nebraska youth account for 84.9% of all unintentional injuries. Source: CDC WISQARS



#### 2003 NEBRASKATEEN DRIVER FACTS: Nebraska Office of Highway

Licensed drivers 16 to 19 years of age represent 8% of all licensed drivers

66% of teen drivers involved in fatal/serious injury crashes were not using safety belts.

#### TEEN DRIVERS WERE INVOLVED IN:

27% of all reported crashes

32% of all crashes between 9:00 p.m. and midnight

23% of all crashes occurred between midnight and 3:00 a.m.

48% of crashes where exceeding the speed limit was the major cause

34% of crashes where failure to yield was the major cause

32% of all single vehicle rollover crashes

26% of crashes where road conditions were wet or snowy

33% of crashes where speed too fast for conditions was the major cause

32% of crashes where a rear-end type collision occurred

20% of crashes where alcohol involvement was a factor

## **Tobacco**

### **Keep Nebraska Youth Tobacco Free. Reduce the percentage of youth using tobacco products in any form.**

Tobacco smoking is the number one preventable health risk associated with morbidity and mortality. Close to one-half million deaths are attributable each year to cigarette smoking. (CDC) If current patterns of smoking behavior continue, an estimated 6.4 million of today's children can be expected to die prematurely from a smoking-related disease. (CDC) **Nearly all first use of tobacco occurs before high school graduation suggesting that if youth can be kept tobacco free, most will never start using a tobacco product.** (CDC-MMWR)

- **In Nebraska the rates of youth cigarette smoking increases with age going from 11.73% in 6<sup>th</sup> grade to 57.37% in 12<sup>th</sup> grade of those whom have used cigarettes in their lifetime. (HHS Risk and Protective Factor Survey-2003).**
  - Every day, approximately 4,000 American youth aged 12-17 tries their first cigarette. (SAMHSA). The younger people begin smoking cigarettes, the more likely they are to become strongly addicted to nicotine. (CDC)
  - Of high school students who are current smokers, 54% have tried to quit in the last 12 months.

Exposure to environmental tobacco smoke (ETS) causes increased risk for serious health effects such as upper respiratory illnesses and asthma. (EPA)

- More than 6 million youth are exposed to secondhand smoke daily.
- Ten million youth aged 12-18 live in a household with at least one smoker.

#### **An Effective Intervention is Available:**

Because four out of five adults who use tobacco began before they reached adulthood, tobacco-prevention activities should focus on school-age children and adolescents.

(CDC) Evidence-based interventions are available for any setting:

- Community-based, integrated, multi-component programs
- Enforcing clean indoor air laws and laws which restrict youth access to tobacco products and/or restrict tobacco advertising
- Media and youth empowerment campaigns combined with other interventions
- Policy approaches -Increasing tobacco taxes, dedicating Tobacco Master Settlement Funds/State funds comprehensive tobacco control programs
- Parents/communities/schools sending clear messages de-normalizing tobacco

#### **Disproportionate Effects Among Subgroups of the Population:**

- Slightly more girls smoke cigarettes than boys: 26% vs. 23%, more boys are using smokeless tobacco: 17% vs. 3%. (2003 YRBS)
- 52% of Native American youth in Nebraska smoke cigarettes. Girls (56.2 %) are slightly more likely to smoke than boys (48.7 %). 19.4 of Native American youth used smokeless tobacco. Boy's (23.2) were more likely to use smokeless tobacco than girls were (14.9%).

**Problem is Worse than the Benchmark or Increasing:**

- The **Healthy People 2010** objective is to reduce to **21%** the percentage of youth in grades 9-12 who used any form of tobacco in the past month.
- In Nebraska, **31%** of Nebraska youth in grades 9-12 used a tobacco product in the past month significantly higher than the **27%** nationally (YRBS)
- In Nebraska, 24.1% of students in grades 9-12 smoked cigarettes on one or more of the last 30 days significantly higher than the 22.9% nationally
- In grades 9-12, 59.6% of current smokers attempted to quit in the past 12 months. This compares to the U.S. rate of 53.8%. The **Healthy People 2010** objective for the percentage of students attempting to quit is **84%**.

**Severity of Consequences:**

Smoking is the single most preventable cause of death in our society. (ACS)

- In the U.S., tobacco causes nearly 1 in 5 deaths
- Tobacco use accounts for about one third of all cancer deaths in the US
- Smoking cigarettes increases the risk of heart disease, which is the number one cause of death in the United States.
- ETS causes about 3,000 lung cancer deaths each year in healthy nonsmokers, and up to 50,000 deaths overall.
- Children whose parents smoke are more likely to suffer from pneumonia, bronchitis, ear infections, coughing, wheezing, increased mucus production, and asthma.

**There is Impetus for Change:**

Both the public and private sectors have acted to help decrease smoking-related deaths and illnesses in this country. In Nebraska there is broad recognition of the problem of tobacco use among youth and substantial support for increased prevention efforts.

- In 2003, 59.7% of Nebraskans said that tobacco use by minors is a serious problem in their community compared to 56.7% offering the same response in 2000. (HHS Tobacco Trend Analysis, 2003)
- Statewide and community coalitions dedicated to increasing prevention efforts and affecting policy
- 80.6% of Nebraskans support no-smoking policies
- Local policies prohibiting tobacco use in schools and public locations
- 100% of Nebraska schools prohibit student tobacco use in school buildings or on school grounds. (2002 SHEP Survey)

**Large Number of People Affected:**

- 27,000 (24%) of Nebraska students in grades 9-12 smoked cigarettes in the past 30 days. (2003 YRBS)
- Close to 35,000 (30.8%) of Nebraska students in grades 9-12 used some form of tobacco in the past 30 days. (2003 YRBS)

## **Alcohol**

Reduce alcohol use among Nebraska youth. High rates of alcohol use results in at-risk behaviors and poor health outcomes. Alcohol abuse is the third leading preventable cause of death in the United States (4% of the total deaths in 2000), and is a factor in approximately 41% of all deaths from motor vehicle crashes. (CDC)

Use of alcohol among teens and young adults is associated with the leading causes of death and injury for this age group (MV crashes, homicides, and suicides). **Alcohol use is also attributed to an increase in sexual activity, unprotected sexual activity and violence (National Council on Alcoholism and Drug Dependence).**

- Teens who consume alcohol are five times more likely to drop out of school than teens who don't. (Ohio State University Extension)
- According the National Institute on Alcohol Abuse and Alcoholism, adolescents who begin drinking before age 15 are four times more likely to develop alcohol dependence than those who begin drinking at age 21.

**In Nebraska 78% of youth in grades 9-12 have had at least one drink in their lifetime, 47% have had a drink within the last 30 days and 21% engaged in heavy (binge) drinking. (2003 YRBS)**

### **An Effective Intervention is Available:**

According to the Institute of Medicine, preventing alcohol use among youth is a collective responsibility shared at three distinct levels: In Nebraska, effective intervention is obtained through:

- State level leadership-coordinate statewide action, i.e. SICA, NePiP,
- Community level mobilization  
SICA Community Coalitions, school programs (Safe and Drug Free)
- Restricting access  
Strengthen laws, promote compliance, and educate parents, servers and sellers

### **Disproportionate Effects Among Subgroups of the Population:**

2003 YRBS data for Nebraska shows:

- More females (49.3%) had one or more drinks in last 30 days (current use), compared to males (43.8%) which compares to national trend.
- Slightly more males (32.6%) binge drink (5+ drinks in a row) than females (31.6%) which compares to national trend.
- More males (31.3%) had their first drink before the age of 13 compared to females (21.8%).

National 2003 YRBS data shows

- More whites (47%) used alcohol within the last 30 days (current use) followed by Hispanic (45.6%) and African American (37.4%).
- Binge drinking is highest among white males (31.8%) and females (31.5%) followed by Hispanic females (29.8%).

### **Problem is Worse than the Benchmark or Increasing:**

2003 YRBS data shows:

- **46.5%** of Nebraska youth in grades 9-12 drank alcohol within the last 30 days, significantly higher than the **44.9%** nationally.
- **32.2%** had 5+ drinks in a row (binge drinking) significantly higher than they **28.3%** nationally. The **Healthy People 2010** objective for binge drinking is to reduce the rate to **2%** for youth aged 12-17.
- The 2003 NE Risk and Protective factor student survey for Region 6 (Douglas, Dodge, Sarpy, and Washington Counties) indicates alcohol use increases with age with **6.5% of 6<sup>th</sup>** grades using alcohol within the last 30 days compared to **48.9% of 12<sup>th</sup>** graders.
- **21%** of Nebraska youth in grades 9-12 drove a car after using alcohol (at least once in the past 30 days), significantly higher than the **12%** nationally.

### **Severity of Consequences:**

Use of alcohol attributes to at-risk behaviors leading to increased morbidity or mortality.

- Nationally, alcohol and other drug use factor in approximately 40% of MV deaths for youth under the age of 24.
- In Nebraska in 2003, of the **5811** motor vehicle crashes for drivers aged 16-20, **207** involved the use of alcohol resulting in **16** fatalities and **191** cases of injury. (NE DMV).
- Youth alcohol use contributes to alcoholism. People who begin using before the age of 15 are **four times** more likely to develop alcoholism than those who begin at age 21. (National Institute of Alcohol Abuse and Alcoholism).
- **30.5%** of Nebraska youth used alcohol or drugs before last sexual intercourse compared to **25.4%** nationally.

### **There is Impetus for Change:**

Nationwide, the total cost of alcohol use by youth, including traffic crashes, violent crime, burns, drowning, suicide attempts, fetal alcohol syndrome, alcohol poisoning and treatment, is more the **\$58 billion** per year (U.S. Dept. of Justice, Office of Juvenile Delinquency Prevention).

- Underage drinking is our nation's No.1 youth drug problem and has become a priority on the nation's policy and public health agenda (MADD, 2003)
- Reducing underage drinking supported by National Institute of Science, Institutes of Medicine and American Academy of Pediatrics.
- **70%** of Nebraska communities have laws that discourage underage use of alcohol and drugs. (2003 NE Risk and Protective Factor Student Survey).

### **Large Number of People Affected:**

- Close to half (**47%**) of youth in grades 9-12 use alcohol (at least one drink in last 30 days). (YRBS 2003)

## Mental Health

### **Reduce mortality, morbidity and negative impact on quality of life associated with mental health conditions in youth.**

“Mental Health Problems” for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention- deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders.

- Mental health problems affect **one in every five** young people at any given time.<sup>16</sup>
- **Twenty percent** of children and teens in juvenile justice facilities have a serious emotional problem. (OJJDP, 2000)

According to the National Mental Health Association, clinical depression is one of the mental, emotional and behavior disorders that can appear during childhood and adolescence.

- Depression in children can lead to school failure, alcohol or other drug use, decreased social functioning and even suicide.

### **An Effective Intervention is Available:**

Access to evidence-based services, and promising practices in the context of a system that ensures thorough and appropriate screening, evaluation, diagnosis, and treatment planning, improves the lives of youth with mental disorders<sup>17</sup>. Examples:

1. Brief hospitalization for suicidal children and adolescents
2. Crisis services (Mobile crisis teams, intensive in-home services, short-term or emergency hospitalization and residential placement)
3. Family-based cognitive behavioral therapy
4. Home-based services
5. Intensive case management
6. Medication and medication management
7. Mentoring
8. Multimodal treatment for ADHD
9. Multi-systemic therapy
10. Nurse home-visiting programs
11. Psycho-education for families
12. School-based services
13. Therapeutic foster care
14. Psychotherapy for youth

### **Disproportionate Effects Among Subgroups of the Population:**

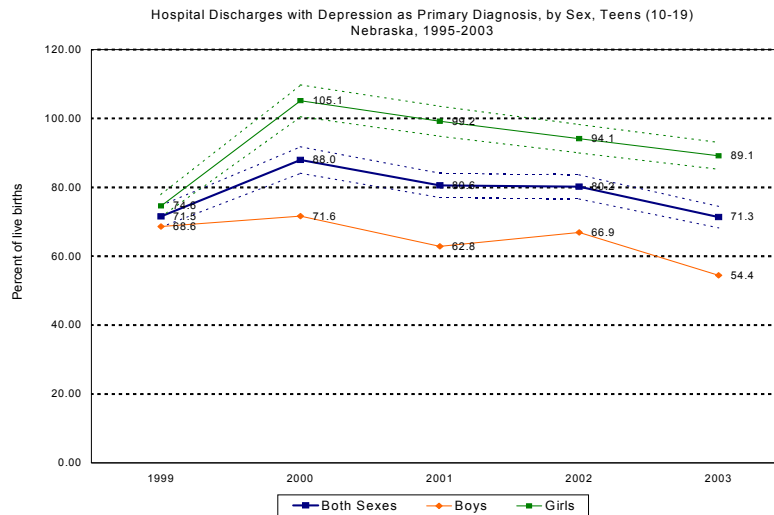
- Males are four times more likely to die from suicide (CDC 2004).
- In Nebraska, Whites (n=65) and African Americans (n=4) accounted for all suicide deaths (ages 10-19) for the years 1999-2002. (CDC-WISQARS)
- Nebraska 2003 YRBS data indicates depression (felt sad or hopeless) is significantly higher among females (31.6%) than males (19.2%).

<sup>16</sup> U.S. Department of Health and Human Services. (1999) *Mental Health: A Report of the Surgeon General*.

<sup>17</sup> Campaign for Mental Health Reform

**Problem is Worse than the Benchmark or Increasing:**

- The **Healthy People 2010** objective for suicide attempts is **5%**.
- In Nebraska, 9% of youth attempted suicide.
- Depression rates for Nebraska girls appear to be increasing.



**Severity of Consequences:**

- Depression triggers risk behaviors and other disorders i.e. drug and alcohol use and eating disorders.
- Depression leads to violent behaviors directed at self and others. The rate of self-inflicted injury among Nebraska youth was 135.7 cases per 100,000 youth ages 10-19 in 2003 (NE Hospital Discharge data). Suicide was the second leading cause of death (11.6%) among Nebraska youth ages 10-19 for 2002.
- Poor mental and emotional health impairs relationships and contributes to school absenteeism and low academic performance

**There is Impetus for Change:**

- Because many youth behaviors are attributed to "normal adjustments", they are often not identified as troubled and do not get the help they need.
- Current policy attention to childhood behavioral health
- Legislative bill: LB 606-Children's Behavioral Health Act

**Large Number of People Affected:**

- Some studies have reported that up to 2.5 %of children and up to 8.3 % of adolescents in the U.S. suffer from depression. An NIMH-sponsored study of 9-17 year olds estimates that the prevalence of any depression is more than 6 % in a 6-month period, with 4.9% having major depression.
- 2003 YRBS data indicates 28,000 (25.3%) Nebraska youth in grades 9-12 felt sad or hopeless everyday for two weeks.

## **E.CSHCN**

Prevalence Nebraska 12.8%, Weighted estimate 57,400 children age 0-17  
United States 12.8%

### Type of Insurance

Private (only) = 62.7% (35,914)  
Public (only) = 24.4% (13,984)  
Private/Public = 9.4% (5,373)  
Uninsured = 3.6% (2,044)

### Estimated Prevalence of CSHCN in Title V and Medicaid Programs

Medicaid = 16,904  
    AABD eligible = 3100 (18.3%)  
    TANF/other = 13,804 (81.7%)  
SCHIP = 1,783  
HCB Waivers = 900  
Katie Beckett Waivers = 40  
MHCP (not covered above) = 393

### Core Outcome #1:

- ◆ 99.8% of newborns screened for six mandated disorders (2004)  
    Newborn Screening programs serve CSHCN (follow-up, referral, and treatment for confirmed conditions)
- ◆ Newborn Hearing screened 98.2% of infants at 67/67 birthing facilities in the state (2004).
- ◆ Parents (hospital births) provided information about supplemental screening (30 additional disorders) by the end of 2004 96.35% newborns received screening
- ◆ ESPDT (2002) utilization for Medicaid enrollees <21 years old in Nebraska = 66%

### Core Outcome #2

- ◆ National CSHCN Survey, 2001 Nebraska = 66.4%  
    United States = 57.5%
- ◆ National CSHCN Survey indicates lower achievement in Hispanic and multi-racial families
- ◆ MHCP service coordinators help families and families are important members of clinic teams
- ◆ Answers4Families provides families access to health information and opportunities to network with other families
- ◆ There are many opportunities to become advocates for CSHCN
- ◆ Family Voices needs restructure base apply for F2F Health Information Center funding through CMS or MCHB

### Core Outcome #3

- ◆ National CSHCN Survey, 2001 Nebraska = 52.6%  
    United States = 54.0%

- ◆ National CSHCN Survey indicates lower achievement in Hispanic and African American families
- ◆ National CSHCN Survey shows unmet needs for mental health, hearing care, communication aids and support services (including respite care)
- ◆ MHCP staff work with families in identifying a medical home
- ◆ MHCP staff collaborate with EDN and HCBW staff in making referrals
- ◆ Difficulty of pediatric specialists from larger cities communicating with Family physicians/pediatricians (medical homes) in small communities (no data)
- ◆ There is little coordination between medical and education service plans except in early intervention (no data)
- ◆ Family physicians may be unable or unwilling to help families of CSHCN access support services (child care, respite care) as well as direct health services, especially mental health
- ◆ 2005 CONNECT reports that the top four unmet non-financial needs identified by MCHP service coordinators are:
  - 1) Child care;
  - 2) Respite ;
  - 3) Dental ; and
  - 4) Psychological services
- ◆ Early Intervention 2004 Planning Regional Teams report that the top issues/needs across the state:
  - 1) Child care;
  - 2) Respite;
  - 3) Awareness/referrals by medical providers for early intervention;
  - 4) Shortage of trained personnel; and
  - 5) Transportation services

#### Core Outcome #4

- ◆ National CSHCN Survey Nebraska = 63.5%  
United States = 59.6%
- ◆ National CSHCN Survey indicates lower achievement in Hispanic families
- ◆ MHCP provides direct health and enabling services to eligible CSHCN not available from Medicaid, SCHIP, or private insurance
- ◆ MHCP services coordinators help families locate payment sources
- ◆ 2005 CONNECT reports that the top unmet financial needs identified by MCHP service coordinators are:
  - 5) Medicaid;
  - 6) Health insurance;
  - 7) Financial and Medicaid Waiver
- ◆ Early Intervention 2004 Planning Regional Teams report that the top financial issues/needs of various kinds are among the most frequently reported gaps and barriers impeding infants and toddlers with disabilities and their families from reaching their goals;

- ◆ National CSHCN Survey shows 20% of Nebraska CSHCN families have incurred financial problems due to child's health condition
- ◆ National CSHCN Survey shows that 25% of Nebraska CSHCN families whose child's health condition has affected employment

#### Core Outcome #5

- ◆ National CSHCN Survey Nebraska = 79.6%  
United States = 74.3%
- ◆ National CSHCN Survey shows core outcome is achieved for all race/ethnicity's
- ◆ MHCP, EDN, HCBW and respite service are integrated using CONNECT
- ◆ Newborn Hearing refers directly to EDN

#### Core Outcome # 6

- ◆ National CSHCN Survey Nebraska = 5.1%  
United States = 5.8%
- ◆ MHCP refers CSHCN at age 14 or earlier to Vocational Rehabilitation system  
MHCP staff works with clinics regarding transition to

#### The Final Three CSHCN Priorities and Documentation

##### **1) Increase capacity of community-based medical home providers to detect and refer for treatment women, children, and youth with emotional and behavioral health conditions.**

This objective is related to **Core Outcome #3: All CSHCN will receive coordinated comprehensive care in a medical home.** The CSHCN definition used in the National Survey includes children requiring treatment/counseling for chronic emotional, behavioral or developmental problems. The National Survey showed that in Nebraska there was a comparatively higher unmet need for mental health services than many other services. The CONNECT system showed that psychological services were among the top four non-financial unmet needs of children in the MHCP Program. According to a recent report by the Child Health Insurance Research Initiative over one-third of CSHCN have a mental health problem, but only one-quarter of caregivers recognize the need for mental health services. Medical home providers, as well as families, are often unaware of the need for mental health referrals and are also uninformed about referral sources. There is a need to connect health care providers and mental health specialists, using **telemedicine** technologies and other initiatives.

##### **2) Increase capacity of Title V Programs for Children with Special Health Care Needs to serve increased numbers of children meeting medical and financial eligibility criteria and who are uninsured or underinsured.**

This objective is related to **Core Outcome #4: All CSHCN will be adequately insured for the services they need.** Most employer-based health insurance plans do not cover essential services needed to keep children with chronic illnesses and disabilities in their homes and communities. An unknown number of children depend on Medicaid because

their health care expenses have exceeded caps in private medical coverage. In spite of these well-known facts, many CSHCN who depend on Medicaid for primary and secondary health coverage either have lost that coverage because of recent restrictions in eligibility for the S-CHIP Program or may lose coverage in light of potential cut-backs and restructuring of the Medicaid Program.

The National Survey of Children with Special Health Care Needs showed that 63.5% of all Nebraska families with CSHCN achieved this core outcome, compared to 59.6% for the nation as a whole. The Survey showed disproportionately lower achievement for Hispanic families. The Survey also showed that 20% of Nebraska families with CSHCN had a child whose health condition caused financial problems for the family. More recent data from the CONNECT system showed that the top unmet financial needs of families whose children are in the MHCP Program are: Medicaid, health insurance, financial and Medicaid Waiver. At the present time there are 393 children who are eligible for the MHCP who are not covered by Medicaid, S-CHIP, Home and Community Based Waiver or Katie Beckett Waiver Programs. Those numbers are projected to increase in the near future along with structural reforms and/or cut-backs in the Medicaid Program. Finally, the 2004 Early Intervention Planning Region Teams reported that financial issues and needs of various kinds were among the most frequently reported problems for families.

The implications for the Title V CSHCN Program (MCHP and DSP) are very serious. This Program funds direct health care services to children whose families have no other source of coverage. As the numbers of eligible children who are uninsured or underinsured increases, they will put increasing pressure on a limited amount of Title V funds allocated to the CSHCN Program. In addition to insuring that the financial capacity to serve this population of children is maintained at necessary levels, the Department must also explore ways to deliver clinics and other services in new and more cost-effective ways. The use of **telemedicine** technology to serve more children across the state is one strategy to implement this objective.

### **3) Build capacity of Title V programs for Children with Special Health Care Needs to provide transition medical and dental clinics for youth with special health care needs 14-21 years.**

A cohort of CSHCN who have survived serious and complex medical conditions with the help of medical technology, as well as systems of support for families in their communities, have now “come of age” and are in transition to adulthood. A key indicator of the state’s performance in serving the transition population of CSHCN is **Core Outcome #6: All youth with special needs will receive services needed to support the transition to adulthood.** The National Survey showed that 5.1% of all Nebraska families with CSHCN achieved this core outcome, compared to 5.8% for the nation as a whole. Although these percentages may not be statistically reliable, they reveal a serious need for refocusing of effort from children to youth with special health care needs. Transition clinics need to include both medical and dental care, since the dental needs of youth with special health care needs are often complex and connected to the underlying chronic illness or disability.

Nebraska Title V  
2004-2005 Needs Assessment - Women

For NAC workgroup use only -  
not for further distribution

Data Source	Health Topic	Indicator	NE Recent Trend (1995-2003)				R/E Disparity in NE Disparity	E Compared to			Comments/observations	Exceptions	
			Num	Denom	Rate or %	Year		U.S.	HP2010				
DEMOGRAPHICS													
Census	Demographics	Distribution of women, by age											
Census	Demographics	18-24	89,002	887,057	10.0%	2003	INCREASING	-	0.1	Higher	-	-	US data are for 2000.
Census	Demographics	25-34	112,244	887,057	12.7%	2003	DECREASING	-	0.1	Lower	-	-	US data are for 2000.
Census	Demographics	35-44	123,313	887,057	13.9%	2003	DECREASING	-	0.2	Lower	-	-	US data are for 2000.
Census	Demographics	Women 18-44 as percentage of total population	324,559	1,740,590	18.6%	2003	DECREASING	-	0.1	Higher	-	-	US data are for 2000.
ANEMIA													
WIC	Hgb/Hct	The percentage of low income women with anemia (low hgb/hct) in 3rd trimester of pregnancy	1,677	7,106	23.6%	2002	-	-	0.3	Lower	20%	Higher	US data are from PNSS, 2002.
WIC	Hgb/Hct	The percentage of low income postpartum women with anemia (low hgb/hct)	9,452	36,494	25.9%	2002	-	-	0.4	Lower	-	-	US data are from PNSS, 2002.
ALCOHOL & TOBACCO USE													
PRAMS	ATOD	The percentage of women who smoked tobacco in the 3 months prior to pregnancy	6,419	23,828	26.9%	2001	-	YES	30.8%	Lower	-	-	US data are from PNSS, 2002
PRAMS	ATOD	The percentage of women who smoked tobacco during the last 3 months of pregnancy	3,579	24,135	14.8%	2001	-	YES	20.3%	Lower	1%	Higher	US data are from PNSS, 2002
Vitals	ATOD	The percentage of women who smoked tobacco during pregnancy	3,574	25,900	13.8%	2003	DECREASING	YES	11.0%	Higher	1%	Higher	US data are from birth certificates, 2003
PRAMS	ATOD	The percentage of women who smoked tobacco post-partum	5,157	24,108	21.4%	2001	-	YES	20.8%	Higher	-	-	US data are from PNSS, 2002
BRFSS	ATOD	The percentage of women who currently smoke	79,968	317,204	25.2%	2003	N.L.C.	YES	20.0%	Higher	12%	Higher	-
PRAMS	ATOD	The percentage of women who used alcohol three months prior to pregnancy	13,540	23,642	57.3%	2001	-	YES	8.8%	Higher	-	-	US data are from PNSS, 2002
PRAMS	ATOD	The percentage of women who used alcohol during the last three months of pregnancy	836	24,028	3.5%	2001	-	YES	0.8%	Higher	6%	Lower	-
Vitals	ATOD	The percentage of women who used alcohol during pregnancy	228	25,900	0.9%	2003	DECREASING	NO	0.8%	N.S.D.	6%	Lower	US data are from birth certificates, 2003
PRAMS	ATOD	The percentage of women who drank alcohol post-partum	10,229	24,108	42.4%	2001	-	YES	-	-	-	-	.racial disparities data are for 2000.
BRFSS	ATOD	The percentage of women who currently drink alcohol	167,797	324,559	51.7%	2003	-	YES	50.4%	Higher	12%	Higher	US data are from PNSS, 2002
BRFSS	ATOD	The percentage of women who binge drink (5+ drinks, 1+ times in the past month )	46,049	314,971	14.6%	2003	N.L.C.	-	8.4%	Higher	6%	Higher	US data are from BRFSS, 2002
BRFSS	ATOD	The percentage of women with heavy alcohol consumption (60+ drinks in the past month)	13,981	313,476	4.5%	2003	N.L.C.	-	4.6%	Lower	-	-	US data are from BRFSS, 2002 "adult women at risk for heavy drinking".
ASTHMA													
HDD	Asthma	The number of women 5-64 with emergency visits with asthma as the primary diagnosis, per 10,000	2,237	687,768	32.53	2003	INCREASING	-	82.4	Lower	50	Lower	HP2010 objective is for women 5-64.
HDD	Asthma	The number of women 5-64 with emergency visits with asthma anywhere mentioned, per 10,000	4,479	687,768	65.12	2003	INCREASING	-	-	-	50	Higher	HP2010 objective is for women 5-64.
HDD	Asthma	The number of women 20-44 with emergency visits with asthma as the primary diagnosis, per 10,000	1,562	298,565	52.32	2003	INCREASING	-	-	-	-	-	-
HDD	Asthma	The number of women 20-44 with emergency visits with asthma anywhere mentioned, per 10,000	3,085	298,565	103.33	2003	INCREASING	-	-	-	-	-	-
HDD	Asthma	The number of hospitalized women 20-44 with asthma as the primary diagnosis, per 10,000	229	298,565	7.67	2003	N.L.C.	-	14.8	Lower	7.7	N.S.D.	US data (2001) and HP2010 objective are for women 5-64.
HDD	Asthma	The number of hospitalized women 20-44 with asthma anywhere mentioned, per 10,000	1,598	298,565	53.52	2003	INCREASING	-	-	-	-	-	-
BRFSS	Asthma	The number and percentage of women 18+ ever told by a doctor that they had asthma	75,256	665,982	11.3%	2002	-	-	13.6%	Lower	-	-	US & Nebraska data from BRFSS, 2002.
CANCER													
Vitals	Cancer	The number and rate of deaths from cancer, per 100,000 women	1,617	887,057	154.1	2003	-	YES	163.1	Lower	159.9	-	US data are for 2002.
Vitals	Cancer	The number and rate of deaths from cancer, per 100,000 women 20-44	73	299,800	24.3	2003	-	YES	23.3	N.S.D.	-	-	-
BRFSS	Breast cancer	The percentage of women 18+ who have ever had a clinical breast exam	602,048	665,982	90.4%	2002	N.L.C.	YES	91.0%	N.S.D.	-	-	-
BRFSS	Breast cancer	a. Within past year	98,677	130,181	75.8%	2002	-	-	-	-	-	-	-
BRFSS	Breast cancer	b. Within past 2 years	18,225	130,181	14.0%	2002	-	-	-	-	-	-	-
BRFSS	Breast cancer	The percentage of women ages 40-49 who have had a clinical breast exam											
BRFSS	Breast cancer	a. Within past year	89,109	130,181	68.5%	2002	N.L.C.	YES	74.4%	N.S.D.	-	-	US and NE data are from BRFSS, 2002. Disparity data are for 2000.
BRFSS	Breast cancer	b. Within past 2 years	16,403	130,181	12.6%	2002	DECREASING	YES	14.6%	N.S.D.	-	-	US and NE data are from BRFSS, 2002. Disparity data are for 2000.
BRFSS	Breast cancer	The percentage of women over 40 years of age who have ever had a mammogram	577,473	665,982	86.7%	2002	INCREASING	YES	90.3%	Lower	70%	Higher	Trend test for women over age 18.
BRFSS	Breast cancer	The percentage of women ages 40-49 who have had a mammogram											
BRFSS	Breast cancer	a. Within past year	86,831	130,181	66.7%	2002	N.L.C.	YES	65.3%	Higher	-	-	US data are from BRFSS, 2002. Disparity data are for 2000.
BRFSS	Breast cancer	b. Within past 2 years	23,563	130,181	18.1%	2002	N.L.C.	YES	19.4%	Lower	-	-	US data are from BRFSS, 2002. Disparity data are for 2000.
CanReg	Breast cancer	The number and rate breast cancer diagnoses (age-adjusted)	437	325,544	134.2	2002	INCREASING	YES	134.8	N.S.D.	-	-	US data are from SEER, 2001
CanReg	Breast cancer	The number and rate of breast cancer deaths per 100,000 women (age-adjusted)	255	887,057	25.0	2001	N.L.C.	-	25.6	N.S.D.	22.3	N.S.D.	US data are from 2002.
Vitals	Breast cancer	The number and rate of breast cancer deaths per 100,000 women (age-adjusted)	244	887,057	24.0	2003	N.L.C.	YES	25.6	N.S.D.	22.3	N.S.D.	US data are from 2003.
BRFSS	Cervical cancer	The percentage of women over 18 years of age who have ever had a Pap smear	625,357	665,982	93.9%	2002	N.L.C.	N.S.D.	95.2%	Lower	97%	Lower	US data are from BRFSS, 2002.
BRFSS	Cervical cancer	The percentage of women 40-49 who have had a Pap smear within the past 3 years	281,407	315,437	89.2%	2002	N.L.C.	YES	90.3%	Lower	90%	Lower	US data are from BRFSS, 2002.
CanReg	Cervical cancer	Cervical cancer diagnosis (age-adjusted)	75	881,697	8.6	2002	N.L.C.	YES	7.9	N.S.D.	-	-	US data are for 2001.
Vitals	Cervical cancer	Cervical cancer deaths (age-adjusted)	14	887,057	1.5	2003	N.L.C.	-	2.6	N.S.D.	2.0	N.S.D.	US data are for 2003.
Vitals	Digestive cancer	Digestive tract cancer deaths (age-adjusted)	175	887,057	15.7	2003	N.L.C.	-	2.6	-	2.0	Higher	US data are for 2003.
CDC	Lung cancer	The number and rate of lung cancer deaths, per 100,000 women (age-adjusted)	364	887,057	41.0	2003	-	-	41.6	N.S.D.	44.9	N.S.D.	US data are for 2003.
CanReg	Skin Cancer	The number and rate of skin cancer (Melanoma) diagnoses (age-adjusted)	128	874,605	14.4	2002	N.L.C.	YES	15.6	N.S.D.	-	-	US data are for 2001.
Vitals	Skin Cancer	The number and rate of skin cancer (Melanoma) deaths (age-adjusted)	14	887,057	1.3	2003	N.L.C.	-	1.7	N.S.D.	2.5	N.S.D.	US data are for 2003.
CARDIOVASCULAR DISEASE & RISK FACTORS													
BRFSS	CVD	The percentage of women who currently smoke	79,967	317,204	25.2%	2003	N.L.C.	YES	20.0%	Higher	12%	Higher	US data are for 2003, and exclude California.
BRFSS	CVD	The percentage of women who are former smokers	48,500	317,204	15.3%	2003	N.L.C.	YES	21.4%	Lower	-	-	US data are from BRFSS, 2003.
BRFSS	CVD	The percentage of women with diabetes	4,878	316,739	1.5%	2003	N.L.C.	-	4.5%	Lower	2.5%	Lower	US data are for 2002.
BRFSS	CVD	The percentage of women with hypertension											US data are from BRFSS, 2003, and ask whether the woman had ever been told she had high cholesterol.
BRFSS	CVD	The percentage of women with high cholesterol	25,354	317,316	8.0%	2003	N.L.C.	YES	24.9%	Lower	16%	Lower	US data are from BRFSS, 2003, and ask whether the woman had ever been told she had hypertension.
BRFSS	CVD	The percentage of women who are overweight (BMI 25-29)	24,797	186,161	13.3%	2003	DECREASING	-	32.1%	Lower	17%	Lower	US data are from BRFSS, 2002.
BRFSS	CVD	The percentage of women who are obese (BMI 30+)	70,438	293,858	24.0%	2003	N.L.C.	YES	21.4%	Higher	-	-	US data are for 2000.
BRFSS	CVD	The percentage of women who are vigorous (20+ min 3+ days/week) or vigorous (20+ min 3+ days/week)	61,975	293,858	21.1%	2003	INCREASING	YES	33.0%	Lower	15%	Higher	US data are for 2000.
BRFSS	CVD	The percentage of women with moderate(>30 min 5+ days/wk)or vigorous (20+min 3+ days/week)	128,109	304,297	42.1%	2003	-	YES	29.0%	Higher	50%	Lower	US data are for 2002.
BRFSS	CVD	The percentage of women who lack of exercise (none outside of work)	61,490	316,960	19.4%	2003	N.L.C.	YES	40.0%	Lower	20%	Lower	US data are for 2002.
BRFSS	CVD	The percentage of women who consume 5+ servings of fruits and vegetables/day	54,610	317,316	17.2%	2003	-	YES	27.0%	Lower	-	-	US data are from BRFSS, 2003.
BRFSS	CVD	The percentage of women who have 3+ of possible 7 risk factors for CVD	122,167	273,916	44.6%	2003	-	YES	-	-	-	-	-

Nebraska Title V  
2004-2005 Needs Assessment - Women

For NAC workgroup use only -  
not for further distribution

COMMUNICABLE DISEASE													
EPI Comm STDs	The number and rate per 100,000 women of reportable sexually transmitted diseases												
EPI Comm STDs	Chlamydia		3,435	875,685	392.26	2003	INCREASING	-	466.9	Lower	-	-	US data are for 2003.
EPI Comm STDs	Gonorrhea		924	875,685	105.52	2003	INCREASING	-	118.8	Lower	19	Higher	US data are for 2003.
EPI Comm STDs	Hepatitis B (new cases)		9	298,565	3.0	2003	-	YES	10.6	Lower	5.1	N.S.D	HP2010 objective is for high-risk groups, 25-39 years.
EPI Comm STDs	Hepatitis B (prevalent cases)		84	298,565	28.0	2003	-	YES	-	Higher	-	-	US data are for 2001.
EPI Comm STDs	Syphilis		1	875,685	0.1	2003	N.L.C.	-	0.8	Lower	0.2	N.S.D	US data are for 2003.
EPI Comm TB	Tuberculosis		no data available						4.3	-	1	-	US data and HP2010 objective are for women of all ages.
HIV	HIV/AIDS	The number and rate per 100,000 of women ages 20-49 with new cases of HIV/AIDS	15	362,576	4.1	2003	N.L.C.	YES	38.5	Lower	1.0	Higher	US data are for women 15-44. HP2010 objective is for women 13+.
HIV	HIV/AIDS	The number and rate per 100,000 of women ages 20-49 living with HIV/AIDS	307	362,576	84.7	2003	-	YES	-	-	-	-	
HEALTH CARE ACCESS													
BRFSS	Access to Hlth Ca	The percentage of women 18+ who have health insurance	261,154	315,609	82.8%	2003	DECREASING	YES	85.0%	Lower	100%	Lower	US data for 2002.
NHS	Access to Hlth Ca	The percentage of women who have health insurance, by age											
NHS	Access to Hlth Ca	18-24	108,714	132,627	82.0%	2000	-	-	-	-	100%	Lower	NE data from Nebraska Household Survey, 2004.
NHS	Access to Hlth Ca	25-44	119,855	132,627	90.4%	2000	-	-	-	-	100%	Lower	NE data from Nebraska Household Survey, 2004.
NHS	Access to Hlth Ca	45-54	122,176	132,627	92.1%	2000	-	-	-	-	100%	Lower	NE data from Nebraska Household Survey, 2004.
NHS	Access to Hlth Ca	0-65	120,876	132,627	91.1%	2000	-	-	85.0%	Higher	100%	Lower	NE data from Nebraska Household Survey, 2004.
CDC	Access to Hlth Ca	The percentage of women 0-65 who have health insurance	119,364	132,627	90.0%	2000	-	-	85.0%	Higher	100%	Lower	US data for 2002.
CDC	Access to Hlth Ca	The percentage of women 18+ with a source of ongoing care	595,752	640,594	93.0%	1998	-	-	90.0%	Higher	96%	Lower	US data for 2002.
BRFSS	Access to Hlth Ca	The percentage of women 18+ who have a personal physician	247,084	316,638	78.0%	2003	-	YES	82.0%	Lower	85%	Lower	US data for 2002.
BRFSS	Access to Hlth Ca	The percentage of women 18+ who could not see physician due to cost	50,090	317,078	15.8%	2003	N.L.C.	YES	11.9%	Higher	7%	Higher	US data for 2000.
BRFSS	Access to Hlth Ca	The percentage of women 18+ who made medical visits, by facility type											
BRFSS	Access to Hlth Ca	Physician's office	260,419	319,898	81.4%	2002	-	YES	-	-	-	-	
BRFSS	Access to Hlth Ca	Public Health clinic	26,362	319,898	8.2%	2002	-	YES	-	-	-	-	
BRFSS	Access to Hlth Ca	Hospital emergency department	1,175	319,898	0.4%	2002	-	-	-	-	-	-	
BRFSS	Access to Hlth Ca	Hospital emergency room	4,524	319,898	1.4%	2002	-	-	-	-	-	-	
BRFSS	Access to Hlth Ca	Urgent Care	3,492	319,898	1.1%	2002	-	-	-	-	-	-	
BRFSS	Access to Hlth Ca	Other medical facility	13,682	319,898	4.3%	2002	-	-	-	-	-	-	
BRFSS	Access to Hlth Ca	No usual place	10,244	319,898	3.2%	2002	-	-	-	-	-	-	
INJURIES, INTENTIONAL (NON-FATAL)													
HDD	Injury	Assault	442	311,977	141.7	2003	N.L.C.	-	13.6*100 or 720.83/100,000	-	1980	Lower	---
INJURIES, UNINTENTIONAL (NON-FATAL) & INJURY PREVENTION													
BRFSS	Inj prevnt	Seatbelt use (nearly always)	280,805	321,037	87.5%	2002	-	YES	0.8	Higher	92%	Lower	US data are from BRFSS, 2002.
HDD	Injury	Rates of hospitalization for nonfatal injuries, per 100,000 women, by treatment site and cause (E-Code)											
HDD	Injury	Falls	5,098	311,977	1634.0	2003	N.L.C.	-	1,983.4	Lower	-	-	
HDD	Injury	Motor Vehicle Crashes/Traffic	3,803	311,977	1219.0	2003	N.L.C.	-	1,698.5	Lower	933	Higher	
HDD	Injury	Overexertion	2,889	311,977	926.2	2003	N.L.C.	-	1,501.1	Lower	338	Higher	
HDD	Injury	Struck against/By	2,520	311,977	807.9	2003	N.L.C.	-	1,739.6	Lower	-	-	
HDD	Injury	Cut/Pierce	1,969	311,977	631.1	2003	N.L.C.	-	811.4	Lower	-	-	
HDD	Injury	Poisoning	340	311,977	109.0	2003	N.L.C.	-	436.0	Lower	292	Lower	US data are for 2002.
HDD	Injury	Self Inflicted	701	311,977	224.8	2003	N.L.C.	-	254.0	Lower	-	-	
MENTAL HEALTH													
BRFSS	Mental health	The percentage of women reporting poor mental health in the past 30 days	226,981	671,542	0.3	2003	-	-	0.4	Lower	-	-	US data are from BRFSS, 2003 for women 18+
	Mental health	a. 1-9 days	95,441	314,206	30.4%	2003	N.L.C.	-	-	-	-	-	US data are from BRFSS, 2003 for women 18+
	Mental health	b. 10+ days	40,587	314,206	12.9%	2003	N.L.C.	-	-	-	-	-	US data are from BRFSS, 2003 for women 18+
HDD	Mental health	The number and rate of women hospitalized with depression as a primary diagnosis	123	311,977	39.4	2003	N.L.C.	-	-	-	-	-	
HDD	Mental health	The number and rate of women hospitalized with depression anywhere mentioned	1,440	311,977	461.6	2003	INCREASING	-	-	Higher	-	-	
Vitals	Mental health	The number and rate of suicides among women 20-44, per 100,000	11	298,565	3.7	2003	DECREASING	-	4.2	N.S.D.	5	N.S.D	US data are for 2002.
MORTALITY													
CDC	Deaths	Deaths from all causes, per 100,000 women (all ages)	8,077	887,057	910.5	2003	N.L.C.	YES	867.8	Higher	-	-	US data are for 2002.
CDC	Deaths	20-29	60	118,638	50.6	2003	N.L.C.	-	56.6	N.S.D.	-	-	US data are for 2002.
CDC	Deaths	30-39	101	113,615	88.9	2003	N.L.C.	-	94.2	N.S.D.	-	-	US data are for 2002.
CDC	Deaths	40-49	233	130,323	178.8	2003	N.L.C.	-	228.6	Lower	-	-	US data are for 2002.
Vitals	Deaths	Top 5 causes of death among women (20-44)											
Vitals	Deaths	Unintentional injury	53	298,565	17.8	2003	INCREASING	-	18.2	N.S.D.	17.5	N.S.D	US data are for 2002.
Vitals	Deaths	Cancer	51	298,565	17.1	2003	N.L.C.	-	22.1	N.S.D.	-	-	US data are for 2002.
Vitals	Deaths	Heart Disease	31	298,565	10.4	2003	N.L.C.	-	10.2	N.S.D.	-	-	US data are for 2002.
Vitals	Deaths	Suicide	11	298,565	3.7	2003	DECREASING	-	4.2	N.S.D.	5	N.S.D	US data are for 2002.
Vitals	Deaths	Homicide	10	298,565	3.3	2003	N.L.C.	-	4.1	N.S.D.	-	-	US data are for 2002.
CDC	Deaths	Deaths from intentional & unintentional injury, women 18-44	91	324,868	28.0	2002	-	-	29.5	N.S.D.	3.0	Higher	US and NE data from WISQARS, 2002
CDC	Deaths	Deaths from intentional injury, women 18-44	12	324,868	3.7	2002	-	-	4.1	N.S.D.	3.0	N.S.D	US and NE data from WISQARS, 2002
CDC	Deaths	Firearm	7	324,868	2.2	2003	-	-	2.2	N.S.D.	-	-	US and NE data from WISQARS, 2004. Includes building fires.
CDC	Deaths	Other	5	324,868	1.5	2003	-	-	1.9	N.S.D.	-	-	US and NE data from WISQARS, 2005
CDC	Deaths	Deaths from unintentional injury, women 18-44	58	324,868	17.9	2002	-	-	18.7	N.S.D.	17.5	N.S.D	US and NE data from WISQARS, 2002
CDC	Deaths	Motor Vehicle Crashes/Traffic	46	324,868	14.2	2003	-	-	10.9	N.S.D.	-	-	US and NE data from WISQARS, 2003
CDC	Deaths	Poisoning	5	324,868	1.5	2003	-	-	5.4	Lower	-	-	US and NE data from WISQARS, 2004
CDC	Deaths	Other	7	324,868	2.2	2003	-	-	2.4	N.S.D.	-	-	US and NE data from WISQARS, 2005
CDC	Deaths	Deaths from injury, undetermined/unspedif intent, women 18-44	21	324,868	6.5	2002	-	-	6.8	N.S.D.	17.5	Lower	US and NE data from WISQARS, 2002
CDC	Deaths	Deaths from neoplasms, per 100,000 women 20-44	73	299,800	24.3	2001	-	YES	23.3	N.S.D.	-	-	
CDC	Deaths	Deaths from circulatory system disorders, per 100,000 women 20-44	40	299,800	13.3	2001	-	-	14.5	N.S.D.	17.5	N.S.D	
CDC	Deaths	Deaths related to pregnancy and the perinatal, per 100,000 women 20-44	3	299,800	1.0	2001	-	-	0.7	N.S.D.	17.5	Lower	

Nebraska Title V  
2004-2005 Needs Assessment - Women

For NAC workgroup use only -  
not for further distribution

ORAL HEALTH													
BRFSS	Oral Hlth	The percentage of women who visited a dentist within the past 12 months	238,853	309,889	77.1%	2003	-	YES	71.5%	Higher	56%	Higher	US data are from BRFSS, 2002.
PRAMS	Oral Hlth	The percentage of postpartum women who visited a dentist in past 12 months	10,902	24,334	44.8%	2001	-	?	-	-	-	-	
BRFSS	Oral Hlth	The percentage of women who had their teeth cleaned in past 12 months	234,102	301,862	77.6%	2003	-	YES	71.9%	Higher	-	-	US data are from BRFSS, 2002.
PREGNANCY - PRENATAL CARE													
PRAMS	PNC	The percentage of women who had a prenatal care visit during the first trimester	19,250	24,306	79.2%	2000	-	YES	84.0%	Lower	90%	Lower	
Vitals	PNC	The percentage of women who had a prenatal care visit during the first trimester	21,735	25,900	83.9%	2003	DECREASING	YES	84.0%	N.S.D.	90%	Lower	
Vitals	PNC	The percentage of women with adequate PNC (Kotelchuck Index)	19,130	25,900	73.9%	2003	N.L.C.	YES	75.0%	Lower	90%	Lower	
PREGNANCY - DELIVERY													
Vitals	MethDel	Method of Delivery											
Vitals	MethDel	Primiparous women who had a cesarean delivery	2,089	9,947	21.00%	2003	-	-	22.0%	Lower	15%	Higher	US and Nebraska data are for 2002.
Vitals	MethDel	Percentage of live births with a vaginal delivery	18,252	25,900	70.47%	2003	DECREASING	NO	72.1%	Lower	-	-	US data are for 2002.
Vitals	MethDel	Percentage of live births with a primary c-section	4,216	25,900	16.28%	2003	INCREASING	YES	15.8%	Higher	-	-	US data are for 2002.
Vitals	MethDel	Percentage of live births with a vaginal delivery after previous c-section (VBAC)	283	25,900	1.09%	2003	DECREASING	YES	1.5%	Lower	-	-	US data are for 2002.
Vitals	MethDel	Percentage of live births with a repeat c-section	3,016	25,900	11.65%	2003	INCREASING	YES	10.2%	Higher	-	-	US data are for 2002.
Vitals	MethDel	Live births with a repeat c-section, as a percentage of women with previous c-section	3,016	3,299	90.00%	2003	-	YES	87.0%	Higher	63%	Higher	US data are for 2002.
Vitals	MethDel	Percentage of live births with a forceps-assisted delivery	74	25,900	0.29%	2003	INCREASING	-	-	-	-	-	
Vitals	MethDel	Percentage of live births with a vacuum-assisted delivery	2,134	25,900	0.22%	2003	N.L.C.	-	-	-	-	-	
PREGNANCY - WEIGHT GAIN													
PRAMS	Pregnancy Wt Gi	The percentage of pregnant women with insufficient weight gain	4,053	21,955	18.5%	2001	-	-	25.7%	Lower	-	-	US data are from PNSS, 2002.
PRAMS	Pregnancy Wt Gi	The percentage of pregnant women with appropriate weight gain (ACOG)	6,523	21,955	29.7%	2001	-	-	43.5%	Lower	-	-	US data are from PNSS, 2002.
PRAMS	Pregnancy Wt Gi	The percentage of pregnant women who exceeded recommended weight gain	11,379	21,955	51.8%	2001	-	-	30.8%	Higher	-	-	US data are from PNSS, 2002.
CDC	BMI	The percentage of pregnant women who were underweight (BMI) prior to pregnancy	1,300	11,108	11.7%	2002	-	-	12.7%	Lower	-	-	Nebraska and US data are from PNSS, 2002.
CDC	BMI	The percentage of pregnant women who were overweight weight (BMI) prior to pregnancy	4,632	11,108	41.7%	2002	-	-	14.4%	Higher	-	-	Nebraska and US data are from PNSS, 2002.
PREVENTIVE HEALTH													
BRFSS	Prvntv Hlth	The percentage of women 18-44 who take vitamins	186,849	324,559	57.6%	2003	-	YES	40.0%	Higher	80%	Lower	US data are from a 2004 MOD / Gallup survey
BRFSS	Prvntv Hlth	Of women 18-44 who take vitamins, the percentage who take multivitamins	176,852	324,559	54.5%	2003	-	-	-	-	-	-	
BRFSS	Prvntv Hlth	Of women 18-44 who take vitamins but not multivitamins, the percentage who take folic aci	175,586	324,559	54.1%	2003	-	-	-	-	-	-	
PRAMS	Prvntv Hlth	The percentage of postpartum women who take vitamins daily	7,152	24,334	29.4%	2001	-	YES	-	-	-	-	
REPRODUCTIVE HEALTH													
BRFSS	Repo Hlth	The percentage of women (18-24 yrs) whose pregnancy was:											
BRFSS	Repo Hlth	a. Intended (wanted sooner or then )	9,617	25,646	37.5%	2000	-	-	-	-	70%	Lower	
BRFSS	Repo Hlth	b. Unintended (wanted later, or not at all )	16,029	25,646	62.5%	2000	-	-	-	-	30%	Higher	
BRFSS	Repo Hlth	The percentage of women (25-34 yrs) whose pregnancy was:											
BRFSS	Repo Hlth	a. Intended (wanted sooner or then )	35,529	51,440	69.1%	2000	-	-	-	-	70%	Lower	
BRFSS	Repo Hlth	b. Unintended (wanted later, or not at all )	15,912	51,440	30.9%	2000	-	-	-	-	30%	Higher	
BRFSS	Repo Hlth	The percentage of women who have had a hysterectomy											
BRFSS	Repo Hlth	age 18-39	3,099	258,247	1.2%	2000	N.L.C.	-	0.0	N.S.D.	-	-	
BRFSS	Repo Hlth	age 40-49	23,588	130,323	18.1%	2000	N.L.C.	-	0.2	N.S.D.	-	-	
BRFSS	Repo Hlth	ages 18+	150,425	671,542	22.4%	2000	N.L.C.	-	0.2	N.S.D.	-	-	







Year	Calendar	1995	1996	1997	1998	1999	2000	2001	2002	2003
population		837,028	844,158	850,777	857,297	863,887	870,081	876,017	881,697	887,057
% Women	18-24	9.56%	9.48%	9.50%	9.64%	9.78%	9.89%	10.00%	10.00%	10.03%
count		79,985	80,059	80,857	82,680	84,507	86,052	87,570	88,154	89,002
18-24	Lower CI	9.14%	9.07%	9.09%	9.22%	9.35%	9.46%	9.56%	9.56%	9.59%
95% CI	Upper CI	9.98%	9.90%	9.92%	10.07%	10.21%	10.32%	10.43%	10.44%	10.47%
	18-24	Regression statistics								
		EST slope	0.00	(1.46)	EST intercept					
		SE slope	0.00	0.18	SE intercept		T-test slope ne 0			
		R2	0.91	0.00	SE v		T-stat	8.46		
		F	71.57	7	DF		Prob T	0.00006		
		SS reg	0.00	0.00	SS resid		Significant	INCREASING		

**Nebraska Title V  
2004-2005 Needs Assessment - Infant Indicators**

For NAC workgroup use only  
Not for further distribution

		Nebraska				U.S.		HP2010			
Data Source	Indicator	Num	Rate or %	Year	Current Racial / Ethnic Disparity?	Recent Trend (1995-2003)	Rate	Compared to US, NE is:	Target	Compared to HP2010, NE is:	Comments/ Observations/ Exceptions
Access to Health Care											
EPSTD	The percent of eligible infants receiving at least one initial or periodic screen	11,811	97.2%	2003	-	-	79.2%	Higher	-	-	US data are for 1998.
EPSTD	The percent of eligible infants referred for corrective treatment	629	5.2%	2003	-	-	15.7%	Lower	-	-	US data are for 1998.
EPSTD	Total eligibles enrolled in managed care	6,150	50.6%	2003	-	-	42.1%	Higher	-	-	US data are for 1998.
Alcohol, Tobacco and Other Drug Use (Maternal)											
PRAMS	The percentage of infants whose mother drank 3 months before pregnancy	13,540	57.3%	2001	YES	-	-	-	-	-	Original HP2010 defined in terms of "Abstinence from drinking alcohol". PRAMS results are weighted, and are based on self-reported data. PRAMS data for 3 months before pregnancy is used as a proxy for 1st trimester exposure; they should be used together with 3rd trimester (last 3 months of pregnancy) estimates when determining exposure to ATOD during pregnancy
PRAMS	The percentage of infants whose mother drank last 3 months of pregnancy	836	3.5%	2001	YES	-	-	-	6%	Lower	
Vital Stats	The percentage of infants whose mother drank during pregnancy	228	0.9%	2003	YES	DECREASING	0.8%	N.S.D.	6%	Lower	
PRAMS	The percentage of infants whose mother smoked 3 months before pregnancy	6,418	26.9%	2001	YES	-	-	-	-	-	PRAMS results are weighted, and are based on self-reported data. Original HP2010 defined in terms of "Abstinence from smoking." PRAMS results are weighted, and are based on self-reported data. US data are for 2002. PRAMS results are weighted, and are based on self-reported data.
PRAMS	The percentage of infants whose mother smoked last 3 months of pregnancy	3,580	14.8%	2001	YES	-	-	-	1%	Higher	
Vital Stats	The percentage of infants whose mother smoked during pregnancy	3,586	13.8%	2003	YES	DECREASING	11.4%	Higher	1%	Higher	
PRAMS	The percentage of infants whose mother currently smokes	5,157	21.4%	2001	YES	-	-	-	-	-	PRAMS results are weighted, and are based on self-reported data. PRAMS results are weighted, and are based on self-reported data.
PRAMS	The percent of infants who are ever in the same room with someone who is smoking (1-24 hrs)	2,414	10.1%	2001	YES	-	-	-	10%	N.S.D.	
Vital Stats	The percent of infants who were exposed in utero to maternal illicit drug consumption	244	1.1%	2003	-	DECREASING	-	-	-	-	
Anemia											
Vital Stats	The percentage of infants born with anemia	4	0.2%	2003	-	DECREASING	-	Lower	-	-	US & HP2010 rates are for children 1-2 years
WIC	The percentage of infants participating in WIC with risk factor(s) for anemia	3,507	13.6%	2003	-	N.L.C.	-	Higher	-	-	Tested rate includes children 6 months - 5 years. WIC participants are more likely to have poorer outcomes than the general population
Births											
Vital Stats	Distribution of births, by maternal race/ethnicity										Urban=Douglas, Lancaster & Sarpy Counties
	White	22,956	88.6%	2003	-	DECREASING	78.9%	Higher	-	-	
	African-American	1,447	5.6%	2003	-	INCREASING	14.7%	Lower	-	-	
	Native American	456	1.8%	2003	-	N.L.C.	1.0%	Higher	-	-	
	Asian	1,041	4.0%	2003	-	INCREASING	5.4%	Lower	-	-	
	Hispanic	3,447	13.3%	2003	-	INCREASING	22.3%	Lower	-	-	
Vital Stats	Distribution of births, by maternal age										
	<20	2,331	9.0%	2003	-	DECREASING	10.3%	Lower	-	-	
	20-24	6,734	26.0%	2003	-	INCREASING	25.2%	Higher	-	-	
	25-29	8,029	31.0%	2003	-	N.L.C.	26.6%	Higher	-	-	
	30+	8,806	34.0%	2003	-	N.L.C.	37.9%	Lower	-	-	
Vital Stats	Distribution of births, by maternal education										
	None	75	0.3%	2003	-	INCREASING	6.0%	Lower	-	-	
	1-8 years	1,171	4.5%	2003	-	INCREASING			-	-	
	9-11 years	3,113	12.0%	2003	-	INCREASING	15.3%	Lower	-	-	
	12 years	6,744	26.0%	2003	-	DECREASING	30.7%	Lower	-	-	
	HS graduate or more	21,539	83.2%	2003	-	DECREASING	77.4%	Higher	-	-	
	13-15 years	6,902	26.7%	2003	-	DECREASING	21.2%	Higher	-	-	
	≥ 16 years	7,887	30.5%	2003	-	INCREASING	25.5%	Higher	-	-	
Vital Stats	Distribution of births, by maternal marital status										
	Married	18,220	70.3%	2003	-	DECREASING	66.6%	Higher	-	-	
	Unmarried	7,680	29.7%	2003	-	INCREASING	34.0%	Lower	-	-	
Vital Stats	Distribution of births, by plurality										
	Singleton	25,019	96.6%	2003	-	N.L.C.	95.1%	Higher	-	-	
	Multiple	881	3.4%	2003	-	N.L.C.	3.2%	N.S.D.	-	-	
Vital Stats	Distribution of births, by urban/rural residence										
	Urban	14,365	55.5%	2003	-	INCREASING	-	-	-	-	
	Rural	11,535	44.5%	2003	-	DECREASING	-	-	-	-	
Vital Stats	Distribution of delivery method, singleton births only										
	Vaginal	17,997	71.9%	2003	NO	DECREASING	73.5%	Lower	-	-	
	VBAC	283	1.1%	2003	YES	DECREASING	1.5%	Lower	-	-	
	Primary C-section	3,715	14.8%	2003	YES	INCREASING	15.8%	Lower	-	-	
	Repeat C-section	2,907	11.6%	2003	YES	INCREASING	10.2%	Higher	-	-	
	Forceps	72	0.3%	2003	-	INCREASING	-	-	-	-	
	Vacuum	58	0.2%	2003	-	N.L.C.	-	-	-	-	

**Nebraska Title V  
2004-2005 Needs Assessment - Infant Indicators**

For NAC workgroup use only  
Not for further distribution

Data Source	Indicator	Num	Rate or %	Year	Current Racial / Ethnic Disparity?	Recent Trend (1995-2003)	Rate	Compared to US, NE is:	Target	Compared to HP2010, NE is:	Comments/ Observations/ Exceptions
<b>Birth Conditions</b>											
Vital Stats	The percentage of newborns born with Meconium Aspiration Syndrome	21	0.10%	2003	-	-	0.13%	Lower	-	-	
Vital Stats	The percentage of newborns born with Respiratory Distress Syndrome (RDS)	205	0.80%	2003	-	DECREASING	0.60%	Higher	-	-	
<b>Birth Conditions - Birth Defects</b>											
Vital Stats	The percentage of births with diagnosed birth defects	636	2.5%	2003	YES	-	-	-	-	-	
Vital Stats	The rate of births diagnosed with birth defects per 1,000 live births plus fetal	636	24.4	2003	-	N.L.C.	-	-	-	-	
Vital Stats	The number and rate of births with neural tube defects per 100,000 live births	13	50.2	2003	-	-	48.0	N.S.D.	30	N.S.D.	US data are for 2000 and are estimated. Confidence interval for Nebraska rate is large.
Vital Stats	The number and rate of births afflicted with spina bifida per 100,000 live	7	27.0	2003	-	-	19.85	N.S.D.	-	-	
Vital Stats	The number and rate of Down's Syndrome per 100,000 live births plus fetal	26	100.4	2003	-	N.L.C.	46.32	Higher	-	-	US data are for 2002.
Vital Stats	The number and rate of Fetal Alcohol Syndrome per 1,000 live births plus	-	0.0	2003	-	-	3.39	-	-	-	
<b>Birth Conditions - Birth Weight</b>											
Vital Stats	The number and rate of low birth weight infants (<2500 g) per 100 live births	1,794	6.9%	2003	YES	N.L.C.	7.8%	Lower	5%	Higher	
Vital Stats	The number and rate of very low birth weight infants (<1500g) per 100 live births	315	1.2%	2003	-	N.L.C.	1.5%	Lower	0.9%	Higher	
Vital Stats	The number and rate of low birth weight (<2500g) per 100 live singleton births	1,281	5.1%	2003	-	INCREASING	-	-	-	-	
Vital Stats	The number and rate of very low birth weight (<1500g) per 100 live singleton births	216	0.9%	2003	-	N.L.C.	-	-	-	-	
Vital Stats	The number and rate of low birth weight (<2500g) per 100 live multiple births	512	59.0%	2003	-	N.L.C.	-	-	-	-	
Vital Stats	The number and rate of very low birth weight (<1500g) per 100 live multiple births	99	11.4%	2003	-	N.L.C.	-	-	-	-	
<b>Birth Conditions - Prematurity</b>											
Vital Stats	The number and percentage of preterm births (<37 weeks gestation)	2,506	9.7%	2003	-	INCREASING	12.0%	Lower	7.6%	Higher	
Vital Stats	The number and percentage of singleton preterm births (<37 weeks gestation)	1,981	7.7%	2003	-	INCREASING	-	-	7.6%	N.S.D.	
Vital Stats	The number and percentage of preterm low birth weight births (<37 weeks gestation & <2500g)	1,327	5.1%	2003	-	N.L.C.	5.2%	N.S.D.	-	-	
<b>Breastfeeding</b>											
PRAMS	The percent of newborns breastfed at the hospital	17,182	74.3%	2001	-	-	70.0%	Higher	75%	Lower	PRAMS results are weighted, and are based on self-reported data.
PRAMS	The percent of newborns breastfed for more than six weeks	12,395	50.8%	2001	-	-	-	-	-	-	PRAMS results are weighted, and are based on self-reported data.
WIC	The percent of infants ever breastfed	16,343	63.1%	2003	-	INCREASING	70.9%	Lower	75%	Lower	WIC participants are more likely to have poorer outcomes than the general population
CDC	The percent of infants ever breastfed	18,778	72.5%	2003	-	-	70.9%	N.S.D.	75%	N.S.D.	National immunization survey.
WIC	The percent of infants breastfed at least six months	5,802	22.4%	2003	-	INCREASING	36.2%	Lower	50%	Lower	WIC participants are more likely to have poorer outcomes than the general population
CDC	The percent of infants breastfed at least six months	9,143	35.3%	2003	-	-	36.2%	N.S.D.	50%	Lower	National immunization survey.
WIC	The percent of infants breastfed at least twelve months	4,015	15.5%	2003	-	INCREASING	17.2%	Lower	25%	Lower	WIC participants are more likely to have poorer outcomes than the general population
CDC	The percent of infants breastfed at least twelve months	4,507	17.4%	2003	-	-	17.2%	N.S.D.	25%	Lower	National immunization survey.
<b>Child Abuse and Neglect</b>											
CPS	The number of infant neglect or abuse reports that were <i>received</i> by Child Protection	1,844	71.2	2003	-	N.L.C.	-	-	-	-	
CPS	The number of infant neglect or abuse reports that were <i>substantiated</i> by Child Protection	577	22.3	2003	-	N.L.C.	-	-	-	-	
CPS	The total number of infants involved in <i>substantiated</i> reports of abuse or neglect	383	14.8	2003	-	N.L.C.	-	-	-	-	
<b>Growth</b>											
WIC	The percent of infants at 12 months who are either <5 percent or >95 percent of weight according to standards of the National Center for Health Statistics										Nebraska data are for children under 2. WIC participants are more likely to have poorer outcomes than the general population
WIC	< 5%	2,060	4.4%	2003	-	DECREASING	-	-	5%	Lower	
WIC	>95%	6,180	13.2%	2003	-	INCREASING	-	-	5%	Higher	
<b>Immunizations</b>											
IMMUN	The percent of infants who received AAP/ACIP recommended										
IMMUN	3+ DTaP	20,548	88.1%	2003	-	-	90.0%	Lower	90%	Lower	
IMMUN	2+ Polio	21,738	93.2%	2003	-	-	95.2%	Lower	90%	Higher	
IMMUN	1+ MMR (19-35 months)	8,583	36.8%	2003	-	-	45.5%	Lower	90%	Lower	
IMMUN	2+ Hib	22,438	96.2%	2003	-	-	95.3%	Higher	90%	Higher	
IMMUN	3+ Hib	13,528	58.0%	2003	-	-	76.9%	Lower	90%	Lower	
IMMUN	2+ HepB	22,531	96.6%	2003	-	-	93.5%	Higher	90%	Higher	
IMMUN	1+ Varicella (19-35 months)	11,312	48.5%	2003	-	-	49.7%	N.S.D.	90%	Lower	
IMMUN	3+ PCV	11,545	49.5%	2003	-	-	29.9%	Higher	na	Lower	
IMMUN	4:3:1	18,800	80.6%	2002	-	-	78.5%	N.S.D.	90%	Lower	Children 19-35 months
IMMUN	The percentage of primary care providers serving infants participating in										
HDD	The number and rate of hospital discharges for vaccine-preventable conditions among infants, per 100,000 population	5	21.2	2002	-	-	na	0	-	0	Includes diphtheria, tetanus, pertussis, polio, H. influenza, measles, mumps, rubella, congenital rubella syndrome and hepatitis B

**Nebraska Title V  
2004-2005 Needs Assessment - Infant Indicators**

For NAC workgroup use only  
Not for further distribution

Data Source	Indicator	Num	Rate or %	Year	Current Racial / Ethnic Disparity?	Recent Trend (1995-2003)	Rate	Compared to US, NE is:	Target	Compared to HP2010, NE is:	Comments/ Observations/ Exceptions
Lead Screening											
EPSDT	Number and percent of infants with blood lead screening tests	108	0.9%	2003	-	-	-	-	-	-	Nebraska screening programs have lost funding.
Environ Hlth	Number and percent of infants with blood lead screening tests	1,606	6.5%	2000	-	-	-	-	-	-	
Environ Hlth	Distribution of blood levels in children less than 12 months										
Environ Hlth	<10 ug/dl	1,578	98.3%	2000	-	-	-	-	-	-	HP2010 Objective is for children ages 1-5.
Environ Hlth	10-14 ug/dl	24	1.5%	2000	-	-	-	-	0%	Higher	
Environ Hlth	15-19 ug/dl	3	0.2%	2000	-	-	-	-	0%	N.S.D.	
Environ Hlth	20-44 ug/dl	1	0.1%	2000	-	-	-	-	0%	N.S.D.	
Mortality											
Vital Stats	A. Fetal Mortality - Deaths occurring between 20 weeks gestation and birth										
Vital Stats	The number and ratio of fetal deaths, per 1,000 live births + fetal	151	5.8	2003	YES	N.L.C.	6.4	N.S.D.	4.1	Higher	US data are from 2001.
Vital Stats	White	120	5.2	2003		N.L.C.	5.5	N.S.D.	4.1	Higher	US data are from 2001.
Vital Stats	African-American	19	13.1	2003		N.L.C.	11.9	N.S.D.	4.1	Higher	US data are from 2001.
Vital Stats	American Indian	6	13.2	2003		N.L.C.	-	-	4.1	N.S.D.	
Vital Stats	Asian	6	5.8	2003		-	-	-	4.1	N.S.D.	
Vital Stats	Hispanic	25	7.3	2003		N.L.C.	-	-	4.1	Higher	
Vital Stats	B. Perinatal mortality - Deaths occurring between 28 weeks gestation and 6 days of age										
Vital Stats	The number and rate of perinatal deaths, per 1000 live births	247	9.5	2003		DECREASING	6.9	Higher	4.5	Higher	US data are for 2002.
Vital Stats	C. Neonatal mortality - Deaths occurring between birth and 28 days of age										
Vital Stats	The number and rate of neonatal deaths, per 1,000 live births	96	3.7	2003		DECREASING	4.7	Lower	2.9	Higher	US data are for 2002.
Vital Stats	D. Postneonatal mortality - Deaths occurring between 28-364 days of age										
Vital Stats	The number and rate of postneonatal deaths per 1,000 live births	45	1.7	2003	YES	DECREASING	2.3	Lower	1.2	Higher	US data are for 2002.
Vital Stats	White	65	2.8	2003		-	1.9	Higher	1.2	Higher	US data are for 2001.
Vital Stats	African-American	13	9.0	2003		-	4.4	N.S.D.	1.2	Higher	US data are for 2001.
Vital Stats	American Indian	5	11.0	2003		-	5.4	N.S.D.	1.2	Higher	US data are for 2001.
Vital Stats	Asian	-	0.0	2003		-	1.6	Lower	1.2	Lower	US data are for 2001.
Vital Stats	Hispanic	11	3.2	2003		-	1.8	N.S.D.	1.2	Higher	US data are for 2001.
Vital Stats	E. Infant Mortality - Deaths occurring between 0-364 days of age										
Vital Stats	The number and rate of infant deaths per 1,000 live births	141	5.4	2003		DECREASING	7.0	Lower	4.5	Higher	US data are for 2002.
Vital Stats	White	111	4.8	2003		DECREASING	5.8	N.S.D.	4.5	N.S.D.	US data are for 2002.
Vital Stats	African-American	23	15.9	2003		N.L.C.	14.1	N.S.D.	4.5	Higher	US data are for 2002.
Vital Stats	American Indian	6	13.2	2003		N.L.C.	8.6	N.S.D.	4.5	N.S.D.	US data are for 2002.
Vital Stats	Asian	1	1.7	2003		-	4.8	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	Hispanic	18	5.2	2003		DECREASING	5.9	N.S.D.	4.5	N.S.D.	US data are for 2002.
Vital Stats	IMR by maternal age, per 1,000 live births										
Vital Stats	<15 yrs	1	40.0	2003	-	-	-	-	4.5	N.S.D.	US data are for 2001.
Vital Stats	15-19 yrs	21	9.1	2003	-	-	10.0	N.S.D.	4.5	Higher	US data are for 2001.
Vital Stats	20-24 yrs	44	6.6	2003	-	-	7.6	N.S.D.	4.5	Higher	US data are for 2001.
Vital Stats	25-29 yrs	34	4.3	2003	-	-	6.1	Lower	4.5	N.S.D.	US data are for 2001.
Vital Stats	30-34 yrs	28	4.7	2003	-	-	5.4	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	35-39 yrs	13	5.4	2003	-	-	6.5	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	≥ 40 yrs	0	0.0	2003	-	-	8.4	Higher	4.5	Higher	US data are for 2001.
Vital Stats	IMR by maternal education, per 1,000 live births										
Vital Stats	0-8 yrs	6	4.8	2003	-	-	6.7	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	9-11 yrs	16	5.1	2003	-	-	9.2	Lower	4.5	N.S.D.	US data are for 2001.
Vital Stats	12 yrs	46	6.8	2003	-	-	7.4	N.S.D.	4.5	Higher	US data are for 2001.
Vital Stats	13-15 yrs	42	6.1	2003	-	-	6.1	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	≥ 16 yrs	31	3.9	2003	-	-	4.3	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	Infant deaths by maternal marital status, per 1,000 live births										
Vital Stats	Married	79	4.3	2003	-	-	5.4	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	Single	62	8.1	2003	-	-	9.7	N.S.D.	4.5	Higher	US data are for 2001.
Vital Stats	Infant deaths by plurality, per 1,000 live births										
Vital Stats	Singleton	124	5.0	2003	-	-	6.0	Lower	4.5	N.S.D.	US data are for 2001.
Vital Stats	Multiple	17	19.3	2003	-	-	32.4	Lower	4.5	Higher	US data are for 2001.
Vital Stats	Infant deaths by prenatal care usage, per 1,000 live births										
Vital Stats	A. Prenatal care initiation 1st trimester (1-3 mos.)	115	5.3	2003	-	-	6.2	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	B. No prenatal care	4	28.0	2003	-	-	34.7	N.S.D.	4.5	N.S.D.	US data are for 2001.
Vital Stats	C. Adequate prenatal care (Kotelchuck index > 79.99%)	109	5.7	2003	-	-	-	-	4.5	Higher	US data are for 2001.
Vital Stats	F. Infant Mortality - Causes of death (rate per 1,000 live births)										
Vital Stats	Birth defects	36	1.4	2003	-	DECREASING	1.4	N.S.D.	1.1	N.S.D.	US data are for 2002.
Vital Stats	Complications of placenta,cord and membranes	15	0.58	2003	-	N.L.C.	0.26	Higher	-	-	
Vital Stats	Maternal complications (premature rupture of membranes)	8	0.31	2003	-	N.L.C.	0.42	N.S.D.	-	-	
Vital Stats	Prematurity (disorders relating to short gestation)	14	0.54	2003	-	N.L.C.	1.2	Lower	-	-	
Vital Stats	Infections relating to perinatal period	1	0.04	2003	-	N.L.C.	0.19	Lower	-	-	
Vital Stats	Other perinatal conditions	8	0.31	2003	-	N.L.C.	-	-	-	-	
Vital Stats	SIDS	24	0.93	2003	YES	N.L.C.	0.6	N.S.D.	0.25	Higher	US data are for 2002.

**Nebraska Title V  
2004-2005 Needs Assessment - Infant Indicators**

For NAC workgroup use only  
Not for further distribution

Data Source	Indicator	Num	Rate or %	Year	Current Racial / Ethnic Disparity?	Recent Trend (1995-2003)	Rate	Compared to US, NE is:	Target	Compared to HP2010, NE is:	Comments/ Observations/ Exceptions
<b>Mortality - Intentional Injury</b>											
CDRT	The number and rate of fatalities during each year (1995-2003) due to intentional injuries, per 100,000 live births										
CDRT	1996 Scalding	1	4.30	1996	-	-	-		-		
CDRT	1997 Blunt Force Trauma (n=1), Chronic Abuse (n=1), Shaken	3	12.87	1997	-	-	-		-		
CDRT	1998 Shaken Baby Syndrome	1	4.25	1998	-	-	-		-		
CDRT	1999 None	-	0.00	1999	-	-	-		-		
CDRT	2000 Shaken Baby Syndrome	1	4.06	2000	-	-	-		-		
CDRT	2001 Shaken Baby Syndrome, Battered Child Syndrome	2	8.06	2001	-	-	-		-		
CDRT	2002 Shaken Baby Syndrome (n=2), Head trauma (n=1)	3	11.82	2002	-	-	-		-		
CDRT	2003 Shaken Baby Syndrome (n=2), Other child abuse (n=1),	4	15.44	2003	-	-	-		-		
CDRT	The number of weapon-related violent deaths, per 100,000 live births	1	0.70	1996-2001	-	-	-		-		
CDRT	The number and rate of infant homicides, per 100,000 live births	8	5.58	1996-2001	-	-	-		-		
CDRT	The number of fatalities during each year (1995-2003) due to unintentional injuries, per 100,000 live births										
CDRT	1996 Suffocation	1	4.30	1996	-	-	-		-		
CDRT	1997 Fall (n=1), Suffocation (n=1), Drowning (n=1)	3	12.87	1997	-	-	-		-		
CDRT	1998 Fire	1	4.25	1998	-	-	-		-		
CDRT	1999 Suffocation/strangulation (n=3), Fall (n=1)	3	12.55	1999	-	-	-		-		
CDRT	2000 Suffocation/strangulation (n=4), Fall (n=1), Drown (n=1)	6	24.35	2000	-	-	-		-		
CDRT	2001 Fire	1	4.03	2001	-	-	-		-		
CDRT	The number and rate of drowning-related deaths, per 100,000 live births	2	1.39	1996-2001	-	-	-		-		
CDRT	The number and rate of suffocation-related deaths, per 100,000 live births	9	6.27	1996-2001	-	-	-		-		
CDRT	The number of deaths due to motor vehicle crashes, per 100,000 live births	11	7.67	1996-2001	-	-	-		-		
CDRT	The number and rate of deaths due to falls, per 100,000 live births	3	2.09	1996-2001	-	-	-		-		
CDRT	The number and rate of deaths due to fires/hot objects/scalding, per 100,000	2	1.39	1996-2001	-	-	-		-		
CDRT	The number and rate of deaths due to poisoning, per 100,000 live births	-	0.00	1996-2001	-	-	-		-		
CDRT	The number and rate of deaths due to firearms, per 100,000 live births	1	0.70	1996-2001	-	-	-		-		
CDRT	The number and rate of deaths due to choking, per 100,000 live births	-	0.00	1996-2001	-	-	-		-		
CDRT	The number and rate of deaths due to cut/pierce injuries, per 100,000 live	-	0.00	1996-2001	-	-	-		-		
<b>Non-Fatal Injury - Unintentional</b>											
HDD	The number and rate of non-fatal injuries, per 10,000 live births	272	115.95	2002	-	-	-		-		
HDD	The number and rate of non-fatal injuries due to the top 5 causes, per 10,000 live births	908	387.06	2002	-	-	-		-		
HDD	The number and rate of injuries due to falls, per 10,000 live births	503	214.42	2002	-	-	-		-		
HDD	The number and rate of non-fatal injuries due to being struck by/against an object, per 10,000 live births	174	74.17	2002	-	-	-		-		
HDD	The number and rate of non-fatal injuries due to a hot object or substance, per 10,000 live births	60	25.58	2002	-	-	-		-		
HDD	The number and rate of infants who received medical treatment for nonfatal unintentional injuries, per 10,000 live births	1,377	586.98	2002	-	-	-		-		
HDD	The number and rate of infants who received medical treatment for nonfatal unintentional injuries, per 10,000 live births, by treatment site				-	-	-		-		
HDD	Outpatient ER	1,180	503.01	2002	-	-	-		-		
HDD	Inpatient	18	7.67	2002	-	-	-		-		
HDD	Outpatient non-ER	179	76.30	2002	-	-	-		-		
<b>Newborn Screening</b>											
NB Screen	The number and percent of newborns screened according to state guidelines for genetic & metabolic disorders*	26,008	99.8%	2003	-	-	-		na		
NB Screen	Percent of newborns screened who "referred" on the initial screen, who received appropriate follow-up to the point of diagnosis, rule-out diagnosis, or ensure in system for further follow-up*.	699	76.9%	2003	-	-	-		-		
NB Screen	Percent of newborns screened who were positive for a disorder on the initial (metabolic) screen, who received appropriate follow-up to the point of diagnosis or rule-out of diagnosis.	105	96.3%	2003	-	-	-		-		
NB Screen	Number diagnosed with a clinically significant disorder from the state required metabolic screen who were entered into treatment or intervention	28	100.0%	2003	-	-	-		-		
NB Screen	The number and percent of newborns screened according to state guidelines for newborn hearing screening*	25,275	97.1%	2003	-	-	-		na		
NB Screen	The number and percent of newborns diagnosed with hearing loss who were entered into appropriate intervention.	34	51.5%	2003	-	-	-		-		
<b>Oral Health</b>											
EPSDT	The percent of eligible infants receiving any dental services	597	4.9%	2003	-	-	-		-		
EPSDT	The percent of eligible infants receiving preventative dental services	271	2.2%	2003	-	-	-		-		
EPSDT	The percent of eligible infants receiving dental treatment services	436	3.6%	2003	-	-	-		-		
PRAMS	The percent of infants always and sometimes taking a bottle to bed	3,143	13.1%	2001	-	-	-		-		

**Nebraska Title V  
2004-2005 Needs Assessment - Infant Indicators**

For NAC workgroup use only  
Not for further distribution

Data Source	Indicator	Num	Rate or %	Year	Current Racial / Ethnic Disparity?	Recent Trend (1995-2003)	Rate	Compared to US, NE is:	Target	Compared to HP2010, NE is:	Comments/ Observations/ Exceptions
<b>Prenatal Care</b>											
PRAMS	The percent of mothers obtaining first trimester care	-	85.6%	2001	YES	-	81.4%	Higher	90.0%	Lower	US data are for 2001.
Vital Stats	The percent of mothers obtaining first trimester care	21,562	83.3%	2003	YES	DECREASING	81.4%	Higher	90.0%	Lower	US data are for 2001.
Vital Stats	Urban	12,133	84.5%	2003		DECREASING	-		-		
Vital Stats	Rural	9,429	81.7%	2003		N.L.C.	-		-		
Vital Stats	The number and rate of mothers receiving adequate prenatal care										
Vital Stats	(Kotelchuck index > 79.99%), per 100 live births	19,122	73.8%	2003	YES	N.L.C.	75.0%	Lower	90%	Lower	
Vital Stats	Urban	10,658	74.2%	2003		DECREASING	-		-		
Vital Stats	Rural	8,464	73.4%	2003		INCREASING	-		-		
Vital Stats	The percent of mothers obtaining intermediate quality prenatal care										
Vital Stats	(Kotelchuck index 50-80%), per 100 live births	4,036	15.6%	2003	-	INCREASING	-		-		
Vital Stats	Urban	2,316	16.1%	2003		INCREASING	-		-		
Vital Stats	Rural	1,720	14.9%	2003		DECREASING	-		-		
Vital Stats	The percent of mothers obtaining inadequate prenatal care (Kotelchuck										
Vital Stats	index < 50%), per 100 live births	2,677	10.3%	2003	-	INCREASING	-		-		
Vital Stats	Urban	1,363	9.5%	2003		INCREASING	-		-		
Vital Stats	Rural	1,314	11.4%	2003		N.L.C.	-		-		
Vital Stats	The percent of mothers obtaining no prenatal care	143	0.55%	2003	-	N.L.C.	1.0%	Lower	-	-	US data are for 2001.
Vital Stats	Urban	81	0.56%	2003		N.L.C.	-		-		
Vital Stats	Rural	62	0.54%	2003		N.L.C.	-		-		
PRAMS	Top three barriers to prenatal care for women who did not receive prenatal care as early as desired										
PRAMS	Unaware of pregnancy	-	36.3%	2000	YES	-	-		-		
PRAMS	Could not get an appointment	-	28.1%	2000	YES	-	-		-		
PRAMS	Not enough money or insurance	-	18.4%	2000	YES	-	-		-		
<b>Preventive Health Practices</b>											
PRAMS	The percentage of infants who always ride in a car seat	-	99.0%	2001	-	-	-		-		PRAMS results are weighted, and are based on self-reported data.
PRAMS	Sleep position (% of infants)				YES	-	-		-		PRAMS results are weighted, and are based on self-reported data.
PRAMS	Side	-	16.2%	2001		-	-		-		
PRAMS	Back	-	65.9%	2001		-	66.0%	N.S.D.	70%	Lower	US data are from 2000. National Infant Sleep Position Study, NIH, NICHD.
PRAMS	Stomach	-	12.4%	2001		-	-		-		
PRAMS	Combination of all 3 Positions	-	5.6%	2001		-	-		-		
<b>Sexually Transmitted Diseases</b>											
HIV	The number and rate of infants born to mothers with HIV infection (perinatal										
HIV	exposed), per 100,000 live births	3	11.6	2003	-	-	-		-		
HIV	The number and rate of infants diagnosed with HIV infection, per 100,000 live										
HIV	births	0	0.0	2003	-	-	-		-		
HIV	The number and rate of infants diagnosed with AIDS, per 100,000 live births										
HIV	The number and rate of infants tested as seroreverters (HIV Negative), per										
HIV	100,000 live births	6	23.2	2003	-	-	-		-		
HIV	The number and rate of infants with birth-related Chlamydia infections, per										
HIV	100,000 live births	13	50.2	2003	-	-	-		-		
EPI Commun Dis	The number and rate of infants with birth-related Herpes infections, per										
EPI Commun Dis	100,000 live births	1	3.9	2003	-	-	-		-		
EPI Commun Dis	The number and rate of infants with congenital syphilis infections, per										
EPI Commun Dis	100,000 live births	-	0.0	2003	-	-	0.25	Lower	1	Lower	US data are for 2002.

Children						NE racial /ethnic disparity?	NE Recent Trend (1995-2003)	NE Compared to				Comments/observations Exceptions
Data Source	Health Topic	Indicator	Num	Denom	Rate or %	Year		U.S.		HP2010		
ACCESS TO CARE												
EPSTD	Access to Hlth Ca	Eligible children receiving at least one initial or periodic screen	35,260	59,370	59.4%	2003	-	N.L.C.	52%	Higher	-	U.S. data: FY2000 EPSTD report data for 26 states combined. Denominator = eligibles who should receive initial or periodic screening. Children aged 1-9 years.
EPSTD	Access to Hlth Ca	Eligible children referred for corrective treatment	2,074	59,370	3.5%	2003	-	N.L.C.	15%	Lower	-	U.S. data: FY2000 EPSTD report data for 26 states combined. Denominator = eligibles who should receive initial or periodic screening. Children aged 1-9 years.
ASTHMA												
Lincoln PS	Asthma	Children 12 months to 9 years with asthma			Data na		-	-	11%		-	U.S. data are for ages 0-11 years, "percent ever told had asthma". From 2002 National Health
Lincoln PS	Asthma	Students in grades K-12 with asthma (LPS)	2,549	31,867	8.0%	2002-2003	-	-	9%	Lower	-	U.S. data are for ages 0-17 years, "current asthma prevalence" (2002). From National Health
Lincoln PS	Asthma	The number of school days missed K-6 due to asthma per year, per student	-	-	5.7	2002-2003	-	-	14.7 million	-	-	Nebraska are data from Lincoln Public Schools. U.S. data are for ages 5-17 years, National
	Asthma	The number of schools K-12 with asthma plans	-	-	Data na		-	-	-	-	-	
HHS-AS	Asthma	The number of Head Starts with asthma plans (16 coordinator/s surveyed)	1	16	6.3%	2003	-	-	-	-	-	
HDD	Asthma	Hospital discharges with asthma anywhere mentioned, per 100,000 children	589	214,190	275.0	2003	-	N.L.C.	-	-	-	
HDD	Asthma	Hospital discharges with asthma as the primary diagnosis, per 100,000 children	284	214,190	132.6	2003	-	N.L.C.	-	-	-	
HDD	Asthma	Emergency room visits with asthma as the primary diagnosis, per 100,000 children, 1999	94	214,190	43.9	1999	-	N.L.C.	947.0	Lower	-	
HDD	Asthma	Emergency room visits with asthma as the primary diagnosis, per 100,000 children, 2000	88	214,190	41.1	2000	-	N.L.C.	0.0	Higher	-	
Child Abuse and Neglect												
CPS	Abuse	The number of child neglect or abuse reports that were received by Child Protective Services (CPS), per 1,000 children 1-9	13,103	214,190	61.2	2003	-	INCREASING	-	-	-	US data are for children under 18. Child Maltreatment 2002
ACYF	Abuse	The number of child neglect or abuse referrals, per 1,000 children 0-17	13,863	439,393	31.6	2002	-	-	35.9	Lower	-	(http://www.acf.hhs.gov/programs/cb/publications/cm02/cm02.pdf).
CPS	Abuse	The number of child neglect or abuse reports that were substantiated by Child Protective Services (CPS), per 1,000 children 1-9	3,186	214,190	14.9	2003	-	INCREASING	-	-	-	
ACYF	Abuse	The number of child neglect or abuse referrals that were substantiated, per 1,000 children 0-17	2,472	439,393	5.6	2002	-	-	10.3	Lower	-	US data are for children under 18. Child Maltreatment 2002
CPS	Abuse	The total number of children involved in substantiated reports of abuse or neglect, per 1,000 children 1-9	2,067	214,190	9.65	2003	-	INCREASING	-	-	-	(http://www.acf.hhs.gov/programs/cb/publications/cm02/cm02.pdf).
ACYF	Abuse	The total number of children who were subjects of substantiated referrals of abuse or neglect, per 1,000 children 0-17	3,909	439,393	8.90	2002	-	-	1.07%	Higher	-	US data are for children under 18. Child Maltreatment 2002
IMMUNIZATION												
IMMUN	IMMUN	Age-appropriate immunizations, by immunization type										
IMMUN	IMMUN	2 yr - (4DTP, 3Polio, 1MMR, 3Hib, 3HepB)	-	-	80.4%	2003	-	INCREASING	75%	N.S.D.	80%	N.S.D. U.S. data: 2002 National Immunization Study. Children aged 19-35 months (born during time period February 1999 - June 2001). HP2010 Objective #14-22.
IMMUN	IMMUN	kdgtn - Polio	23,058	23,919	96.4%	2003	-	N.L.C.	96%	Higher	95%	Higher
IMMUN	IMMUN	kdgtn - DTP/DTaP/DT	23,441	23,919	98.0%	2003	-	N.L.C.	96%	Higher	95%	Higher
IMMUN	IMMUN	kdgtn - Measles	22,938	23,919	95.9%	2003	-	N.L.C.	96%	Higher	95%	Higher
IMMUN	IMMUN	kdgtn - Rubella	22,938	23,919	95.9%	2003	-	N.L.C.	96%	N.S.D.	95%	Higher
IMMUN	IMMUN	kdgtn - Mumps	22,938	23,919	95.9%	2003	-	N.L.C.	96%	N.S.D.	95%	Higher
IMMUN	IMMUN	kdgtn - Hepatitis B	23,393	23,919	97.8%	2003	-	INCREASING	96%	Higher	95%	Higher
LEAD												
Environ Hlth	Lead Screen	Distribution of blood levels in children ages 1-6										Children aged<72 months for whom blood lead surveillance data were reported to CDC. 1997-2001. Reported in MMWR Surveillance Summaries, Sept. 12, 2003/52(SS10):1-21.
Environ Hlth	Lead Screen	<10 ug/dl	11,198	11,688	95.8%	2000	Yes	N.L.C.	96.9%	Lower	100%	Lower
Environ Hlth	Lead Screen	10-14 ug/dl	307	11,688	2.6%	2000	-	-	1.9%	Higher	0%	Higher
Environ Hlth	Lead Screen	15-19 ug/dl	84	11,688	0.7%	2000	-	-	0.7%	N.S.D.	0%	Higher
Environ Hlth	Lead Screen	20-44 ug/dl	88	11,688	0.8%	2000	-	-	0.6%	Higher	0%	Higher
Environ Hlth	Lead Screen	45-69 ug/dl	5	11,688	0.0%	2000	-	-	0.0%	N.S.D.	0%	Higher
Environ Hlth	Lead Screen	>70 ug/dl	6	11,688	0.1%	2000	-	-	0.0%	Higher	0%	Higher
EPSTD	Lead Screen	Number of screening blood lead tests (1-5yrs)	7,213	46,598	15.5%	2003	Yes	INCREASING	15.8%	N.S.D.	-	U.S. data: EPSTD data for 26 selected states, FY2000
MORTALITY												
Vitals	Mortality	Child deaths (per 100,000)										
Vitals	Mortality	1 - 4 years	29	93,700	30.9	2002	Yes	N.L.C.	31.2	N.S.D.	18.6	Higher
Vitals	Mortality	5 - 9 years	24	118,356	20.3	2002	Yes	N.L.C.	15.2	N.S.D.	12.3	N.S.D.
Vitals	Mortality	The number and rate of fatalities due to homicide per 100,000 children ages 1-9			1.4	2002	Yes	N.L.C.	1.6	N.S.D.	2.7	N.S.D.
Vitals	Mortality	The number and rate of fatalities due to unintentional injuries (including MVC) per 100,000 children ages 1-9			10.8	2002	Yes	N.L.C.	7.9	N.S.D.	17.5	Lower
Vitals	Mortality	The number and rate of fatalities due to MVC per 100,000 children ages 1-9	7	212,612	3.3	2002	Yes	N.L.C.	3.2	N.S.D.	9.2	Lower
Vitals	Mortality	The number and rate of fatalities due to asthma per 100,000 children ages 1-9	1	214,190	0.5	2003	-	-	3.0	Lower	1.0	N.S.D.
Vitals	Mortality	The number and rate of deaths due to cancer per 100,000 children ages 1-9	6	214,190	2.8	2003	-	-	3.7	N.S.D.	-	US data are for 2002 and children 1-14.
Vitals	Mortality	The number and rate of fatalities due to congenital anomalies per 100,000 children ages 1-9	11	214,190	5.1	2003	-	-	2.8	N.S.D.	-	US data are for 2002 and children 1-14.
NUTRITIONAL STATUS												
WIC	Weight	The percent of children 1-4 years who are anemic (low Hb/Hct)	2997	22,893	13.1%	2003	Yes	N.L.C.	12.8%	N.S.D.	-	Nebraska and US data are from PNSS, 2003. Trends are based on children 0-5
WIC	Weight	The percent of children 1-4 years with short stature (<5% height/age)	1178	25,589	4.6%	2003	Yes	INCREASING	6.2%	Lower	5%	Lower
WIC	Weight	The percent of children 1-4 years who are underweight (<5% weight/age)	1044	25,589	4.1%	2003	Yes	DECREASING	5.2%	Lower	5%	Lower
WIC	Weight	The percent of children 1-4 years who are overweight (>95% weight/age)	3823	25,589	14.9%	2003	Yes	INCREASING	13.6%	Higher	5%	Higher
WIC	Weight	The percent of children 2-4 years who are at risk for overweight (>85% & <95% weight/age)	2776	17,242	16.1%	2003	Yes	INCREASING	15.7%	N.S.D.	5%	Higher
WIC	Weight	The percent of children 2-4 years who are overweight (>95% weight/age)	2310	17,242	13.4%	2003	Yes	INCREASING	14.7%	Lower	5%	Higher
CVH	Weight	The percent of children in grades K-4 who are Underweight (<5% weight/age)	443	16,405	2.7%	2003	-	-	-	-	5%	Lower
CVH	Weight	The percent of children in grades K-4 who are Healthy Weight (>5% but <85% weight/age)	10778	16,405	65.7%	2003	-	-	-	-	80%	Lower
CVH	Weight	The percent of children in grades K-4 who are At Risk for Overweight (>85% but <95% weight/age)	2740	16,405	16.7%	2003	-	-	-	-	10%	Higher
CVH	Weight	The percent of children in grades K-4 who are Overweight (>95% weight/age)	2444	16,405	14.9%	2003	Yes	-	15.8%	Lower	5%	Higher
CVH	Weight	The percent of children in grades K-4 who are Overweight (>95% weight/age)	2444	16,405	14.9%	2003	Yes	-	15.8%	Lower	5%	Higher

children													
Data Source	Health Topic	Indicator	Num	Denom	Rate or %	Year	NE racial /ethnic disparity?	NE Recent Trend (1995-2003)	NE Compared to				Comments/observations Exceptions
ORAL HEALTH													
EPSDT	Oral Hlth	Eligible children receiving any dental services	32,721	59,370	55.1%	2003	-	N.L.C.	35%	Higher	-	-	U.S. data: FY2000 EPSDT report data for 26 states combined. Denominator = eligibles who should receive initial or periodic screening. Children aged 1-9 years.
EPSDT	Oral Hlth	Eligible children receiving <b>preventative</b> dental services	28,197	59,370	47.5%	2003	-	N.L.C.	30%	Higher	-	-	U.S. data: FY2000 EPSDT report data for 26 states combined. Denominator = eligibles whc should receive initial or periodic screening. Children aged 1-9 years.
EPSDT	Oral Hlth	Eligible children receiving dental <b>treatment</b> services	15,554	59,370	26.2%	2003	-	N.L.C.	17%	Higher	-	-	U.S. data: FY2000 EPSDT report data for 26 states combined. Denominator = eligibles whc should receive initial or periodic screening. Children aged 1-9 years.
NHSS	Oral Hlth	The percent of third grade children who have received protective sealants on at least onesurvey in field				2005	-	-	26%	-	50%	Lower	U.S. data: 1988-1994 data for third-grade children (NHANES).
TOBACCO EXPOSURE													
Tobacco Survey	Smoke Exposr	The percent of households with children exposed to tobacco smok											
													NE data: 1998-2000 BRFSS. U.S. data: Children under age 7 years. 1999 Survey on Radon Awareness and Environmental Tobacco Issues, U.S. Environmental Protection Agency, Office of Air and Radiation. Households with respondent answering "yes" to question, "Do you allow anyone to smoke in your home on a regular basis?"
Tobacco Survey	Smoke Exposr	Age < 5	276	1,168	24.0%	1998-2000	-	-	19%	Higher	-	-	
Tobacco Survey	Smoke Exposr	5-12 yrs	461	1,635	27.1%	1998-2000	-	-	-	-	-	-	
Tobacco Survey	Smoke Exposr	The percent of children who have been exposed to tobacco smoke in their hom											
Tobacco Survey	Smoke Exposr	Age < 5	146	925	15.8%	2003	-	-	20%	Lower	10%	Higher	U.S. data: Children under age 6 years. 1998 National Health Interview Survey. HP2010 Objective #27-09.
Tobacco Survey	Smoke Exposr	5-12 yrs	324	1,157	28.0%	2003	-	-	18%	Higher	-	-	U.S. data: Blood cotinine more than 1.0 ng/ml among children aged 4-11 years. 1999-2000 data from NHANES.
UNINTENTIONAL INJURY, NONFATAL													
HDD	Injury	Unintentional nonfatal injuries -Top 5 preventable causes, per 100,000 children.											
													HP2010 Objective #15-14. No target set and no baseline data available
HDD	Injury	Fall	3220	214,190	1,503.3	2003	-	N.L.C.	4,319.8	Lower	-	-	U.S. data: WISQARS non-fatal injury data, children age 1-9 years, 2003. National estimates of nonfatal injuries treated in U.S. hospital emergency departments, including those admitted as inpatients.
HDD	Injury	Struck by/against	2129	214,190	994.0	2003	-	N.L.C.	2,183.1	Lower	-	-	*
HDD	Injury	Cut/pierce	645	214,190	301.1	2003	-	N.L.C.	592.3	Lower	-	-	*
HDD	Injury	Other Unintentional	624	214,190	291.3	2003	-	N.L.C.	133.2	Higher	-	-	*
HDD	Injury	Environmental (including bites/stings)	527	214,190	246.0	2003	-	N.L.C.	639.1	Lower	-	-	*
HDD	Injury	Top 5 sub total	7145	214,190	3,335.8	2003	-	N.L.C.	7,867.5	Lower	-	-	*
HDD	Injury	Unintentional nonfatal injuries - All others, per 100,000 children.	3301	214,190	1,541.2	2003	-	N.L.C.	10,752.9	Lower	-	-	*
INTENTIONAL INJURY, NONFATAL													
HDD	Injury	Total intentional nonfatal injuries, per 100,000 children											
			98	214,190	45.9	2002	-	N.L.C.	248.4	Lower	-	-	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
1	YOUTH														
2															
											NE Compared To				
3	Data Source	Health Topic	Indicator				Rate or %	Year	Current R/E Disparity in NE?	NE Recent Trend (1995- 2003)	U.S.		HP2010		Comments /observations Exc eptions
4	DEMOGRAPHICS														
5	CENSUS		Percentage of population 10-19 yrs of age												
6	CENSUS		10-14				7.3%	2003	YES	DECREASING	7.3%	N.S.D.	-	-	
7	CENSUS		15-19				7.5%	2003	YES	N.L.C.	7.2%	Higher	-	-	
8	ACCESS TO MEDICAL CARE														
9	EPSDT	Access to Hlth Care	Eligibles who received at least one initial or periodic screen				34.9%	2003	-	-	-	-	-	-	
10	EPSDT	Access to Hlth Care	Eligibles referred for corrective treatment				2.0%	2003	-	-	-	-	-	-	
11	EPSDT	Access to Hlth Care	Eligibles enrolled in managed care				51.5%	2003	-	-	-	-	-	-	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
21	Vital Records	Deaths	Neonatal deaths to teen moms age <15, per 100,000 girls 10-14				1.6	2003	YES	-	11.1	Lower	2.9	N.S.D.	Live born infants of at least 28 wks gestation but less than 7 days old, per 1,000 live births + fetal deaths
22	Vital Records	Deaths	Neonatal deaths to teen moms age 15-19, per 100,000 girls 15-19				23.6	2003		-	6.3	Higher	2.9	Higher	Live born infants of at least 28 wks gestation but less than 7 days old, per 1,000 live births + fetal deaths
23	Vital Records	Deaths	Infant deaths to teen moms age <15, per 100,000 girls 10-14				1.6	2003	YES	-	17.6	Lower	4.5	N.S.D.	Live births of any gestational age less than one year old. Includes neonatal deaths
24	Vital Records	Deaths	Infant deaths to teen moms age 15-19, per 100,000 girls 15-19				33.0	2003		-	10.3	Higher	4.5	Higher	Live births of any gestational age less than one year old. Includes neonatal deaths
25	CHILD ABUSE & NEGLECT														
26	CPS	Child abuse	The number of child neglect or abuse reports that were received by Child Protective Services (CPS), per 1				25.7	2003	-	INCREASING	-	-	-	-	
27	CPS	Child abuse	The number of child neglect or abuse reports that were substantiated by Child Protective Services (CPS),				6.5	2003	-	INCREASING	-	-	-	-	
28	CPS	Child abuse	The total number of childs involved in substantiated reports of abuse or neglect, per 1,000 youth 10-19				4.4	2003	-	INCREASING	-	-	-	-	
29	COMMUNICABLE DISEASE														
30	EPI Comun Diseas	STDs	Reportable sexually transmitted diseases, per 100,000 youth ages 10-19, by cause:												

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
															US rate is for ages 10-14 (23.2) / 15-19 (44.3.4)
31	EPI Comun Diseas	STDs			Gonorrhea		199.3	2003	-	N.L.C.	231.7	Lower	-	-	
32	EPI Comun Diseas	STDs			Chlamydia		657.2	2003	-	N.L.C.	-	-	-	-	
33	EPI Comun Diseas	STDs			Hepatitis B		data not available	2003	-	-	-	-	-	-	
34	EPI Comun Diseas	STDs			Syphilis		0.23	1999-2003	-	N.L.C.	-	-	-	-	US data are for childr en under 13.
35	HIV	HIV/AIDS			The number and rate per 100,000 of girls ages 10-19 with new cases of HIV/AIDS		0.38		-	-	5.6		-		
36	HIV	HIV/AIDS			The number and rate per 100,000 of girls ages 10-19 living with HIV/AIDS		data not available	2003	-	-	-		-		
37	IMMUNIZATIONS														
38	IMMUN	IMMUN			Have received hepatitis B series, MMR and Td boosters, current AAP/ACIP schedule (7th grade entry)					-					
39	IMMUN	IMMUN			Booster TD - Up-To-Date			-	2003	-	91%	-	90%	-	U.S. Data for 2002. Objective for ages 13-15 and reads "3 or more doses"
40	IMMUN	IMMUN			Hep B Series - Up-To-Date		80.6%		2003	-	78%	N.S.D.	90%	Lower	
41	IMMUN	IMMUN			MMR2 Series - Up-To-Date		96.0%		2003	-	92%	Higher	90%	Higher	
42	IMMUN	IMMUN			Varicella - Up-To-Date			-	2003	-	69%		90%		
43	INJURIES, INTENTIONAL														
44	HDD	Injury			Rate of hospital discharges for intentional, nonfatal (assault) injuries, per 100,000 youth		143.5	2003	-	-	1,030.1	-	-	-	data are not age-adjusted, and are based on 2003 injury reports from emergency department visits (WIS QARS). Nebraska data are based on emergency

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
															data are not age-adjusted, and are based on 2003 injury reports from emergency department visits (WIS QARS). Nebraska data are based on emergency
45	HDD	Injury / Suicide	Rate of ER & inpatient visits for self-inflicted injuries for youth by cause, per 100,000 youth				112.8	2002	-	INCREASING	138.2	Lower	-	-	
46	HDD	Injury / Suicide	Poisoning				19.8	2002	-	N.L.C.	40.0	Lower	-	-	
47	HDD	Injury / Suicide	Cut/Pierce				1.6	2002	-	-	0.2	N.S.D.	-	-	
48	HDD	Injury / Suicide	Fall				0.8	2002	-	-	0.1	N.S.D.	-	-	
49	HDD	Injury / Suicide	Firearm				0.8	2002	-	-	34.4	Lower	-	-	
50	HDD	Injury / Suicide	Other				135.7	2002	-	INCREASING	213.0	Lower	-	-	
51	HDD	Injury / Suicide	Total												
52	INJURIES, UNINTENTIONAL														
															US data are age-adjusted based on injury reports from emergency department visits (WIS QARS).
53	HDD	Injury	Rate of hospital discharges for unintentional, nonfatal injuries, per 100,000 youth												
54			Top five causes (Nebraska)												
55	HDD	Injury	Struck by/against unintentional				2,791	2002	-	INCREASING	2,817	N.S.D.	-	-	
56	HDD	Injury	Fall unintentional				2,248	2002	-	INCREASING	2,787	Lower	-	-	
57	HDD	Injury	Motor Vehicle traffic unintentional				1,257	2002	-	INCREASING	2,410	Lower	-	-	
58	HDD	Injury	Overexertion unintentional				1,221	2002	-	INCREASING	1,594	Lower	-	-	
59	HDD	Injury	Unspecified unintentional				1,008	2002	-	-	632	Higher	-	-	
60	HDD	Injury	Subtotal (Top five Nebraska causes)				8,524	2002	-	INCREASING	10,141	Lower	-	-	
61	HDD	Injury	All others				2,968	2002	-	INCREASING	2,210	Higher	-	-	
62	HDD	Injury	Treatment site - Outpatient-ER					8,608	2002	-	INCREASING	0	-	-	-
63	HDD	Injury	Treatment site - Inpatient					187	2002	-	N.L.C.	0	-	-	-
64	HDD	Injury	Treatment site - Outpatient-Non ER					2,698	2002	-	INCREASING	0	-	-	-
65	HDD	Injury	Total all treatment sites				11,493	2002	-	INCREASING	12,351	Lower	-	-	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
66	<b>MENTAL HEALTH</b>														
67	HDD	Mntal Health				Hospital discharges with depression anywhere mentioned, per 100,000 youth	167.9	2003	-	-	-	-	-	-	
68	HDD	Mntal Health				Boys	111.9	2003	-	N.L.C.	-	-	-	-	
69	HDD	Mntal Health				Girls	227.0	2003	-	N.L.C.	-	-	-	-	
70	HDD	Mntal Health				Hospital discharges with depression as primary diagnosis, per 100,000 youth 10-19	70.4	2003	-	-	-	-	-	-	
71	HDD	Mntal Health				Boys	53.7	2003	-	N.L.C.	-	-	-	-	
72	HDD	Mntal Health				Girls	88.0	2003	-	N.L.C.	-	-	-	-	
73	YRBS	Mntal Health				Felt sad/hopeless almost every day for two+ weeks that stopped doing a usual activity, in last year, per 10	25.3%	2003	-	-	-	-	-	-	
74	YRBS	Mntal Health				Boys	19.2%	2003	-	-	-	-	-	-	
75	YRBS	Mntal Health				Girls	31.6%	2003	-	-	-	-	-	-	
76	YRBS	Injury				Seriously consider attempting suicide in the past 12 months, per 100 youth 15-19.	17.9%	2003	-	-	16.9%	Higher	-	-	
77	YRBS	Mntal Health				Boys	12.2%	2003	-	-	-	-	-	-	
78	YRBS	Mntal Health				Girls	24.0%	2003	-	-	-	-	-	-	
79	YRBS	Injury				Made a plan about how attempt suicide during past 12 months, per 100 youth 15-19.	17.2%	2003	-	-	16.5%	N.S.D.	-	-	
80	YRBS	Mntal Health				Boys	14.5%	2003	-	-	-	-	-	-	
81	YRBS	Mntal Health				Girls	20.1%	2003	-	-	-	-	-	-	
82	YRBS	Injury				Actually attempted suicide 1 or more times in last 12 months, per 100 youth 15-19.	8.8%	2003	-	-	8.5%	N.S.D.	-	-	
83	YRBS	Mntal Health				Boys	6.4%	2003	-	-	-	-	-	-	
84	YRBS	Mntal Health				Girls	11.3%	2003	-	-	-	-	-	-	
85	YRBS	Injury				Percentage of students whose attempted suicide during the past 12 months resulted in an injury, poisonin	Data Not Available	2003	-	-	2.9%		1%		US data for 2003. HP 2010 Objective for grade s 9-12 reads "attempts requiring hospitalization."
86	<b>MORTALITY</b>														
87		Deaths				Deaths to youth ages 10-14, per 100,000	20.5	2002	YES	N.L.C.	19.5	N.S.D.	16.8	N.S.D.	US data are for 2002.
88		Deaths				Deaths to youth ages 15-19, per 100,000	59.6	2002	YES	N.L.C.	67.8	N.S.D.	39.8	Higher	US data are for 2002.
89		Deaths				The number and rate of fatalities due to homicide per 100,000 youth ages 10-14 and 15-19									Racial disparity data are for 2000-2002.
90		Deaths				Age 10-14	0.8	2002		-	1.0	N.S.D.	-	-	
91		Deaths				Age 15-19	4.5	2002		-	9.3	Lower	-	-	
92		Deaths				The number and rate of fatalities due to suicide per 100,000 youth ages 10-14 and 15-19									Racial disparity data are for 2000-2002.
93		Deaths				Age 10-14	0.8	2002		-	1.2	N.S.D.	-	-	
94		Deaths				Age 15-19	9.8	2002		-	7.4	N.S.D.	-	-	
95		Deaths				The number and rate of fatalities due to unintentional injuries (not including MVC) per 100,000 youth ages									Racial disparity data are for 2000-2002.
96		Deaths				Age 10-14	9.5	2002		-	-	N.S.D.	-	-	
97		Deaths				Age 15-19	45.9	2002		-	-	N.S.D.	-	-	
98		Deaths				The number and rate of fatalities due to MVC per 100,000 youth ages 10-14 and 15-19									
99		Deaths				Age 10-14	0.8	2002		-	3.5	Lower	-	-	MVC

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
									YES						HP20 10 objec tive for ages 15- 24. Racia l dispa rity data are for 2000- 2002
100		Deaths			Age 15-19		9.8	2002		-	27.7	Lower	-	-	
101		Deaths			The number and rate of fatalities due to MVC involving alcohol per 100,000 youth ages 10-14 and 15-19										
102		Deaths			Age 0-18		0.85	2002	-	-	-	Lower	-	-	
															US data for 2002. Obje ctive for ages 5-14
103		Deaths			The number and rate of fatalities due to asthma per 100,000 youth ages 10-14 and 15-19		0.8			-	3	Lower	1.0	-	
104		NUTRITIONAL STATUS													
															Targ ets base d on norm al distri butio n.
105					Nutritional status of students, grades 5-12										
106	CVH	Weight			Underweight (<5%)		2.1%	2002-2003	-	-	-	-	5%	Lower	
107	CVH	Weight			Healthy weight (>5% but <85%),		63.7%	2002-2003	-	-	-	-	80%	Lower	
															US data are from YRB S, 2003
108	CVH	Weight			At risk for overweight (>85% but <95%)		17.3%	2002-2003	-	-	15.4%	Higher	10%	Higher	US data are from YRB S, 2003
															US data are from YRB S, 2003
109	CVH	Weight			Overweight (>95%)		16.9%	2002-2003	-	-	13.5%	Higher	5%	Higher	
110	ORAL HEALTH														
111	EPSDT	Oral Hlth			The percent of youth who have received any dental services		63.2%	2003	-	-	-	-	-	-	
112	EPSDT	Oral Hlth			The percent of eligible youth receivingpreventative dental services		53.9%	2003	-	-	-	-	-	-	
113	EPSDT	Oral Hlth			The percent of eligible youth receivingdental treatment services		33.9%	2003	-	-	-	-	-	-	
															HP20 10 objec tive reads for age 15
114	EPSDT	Oral Hlth			14 years old with protective sealants on occlusal surfaces of second permanent molars Also on Oral Hlth	Data Not Available		2003	-	-	-	-	50%	-	
															HP20 10 objec tive reads "Dec ay on perm anent teeth untre ated"
115	EPSDT	Oral Hlth			15 years old with one or more untreated carious permanent teeth. Also on Oral Hlth pg	Data Not Available		2003	-	-	-	-	15%	-	
116	REPRODUCTIVE HEALTH														
117	Vital Stats	BRTHS			Percentage of births that are to adolescent females										
															2003 US data are preli minar y.
118	Vital Stats	BRTHS			a. Age 10-14		0.1%	2003	-	DECREASING	0.16%	Lower	-	-	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
119	Vital Stats	BRTHS			b. Age 15-19		8.9%	2003	-	DECREASING	10.1%	Lower	-	-	2003 US data are preliminary.
120	Vital Stats				c. Age 10-19		9.0%	2003	-	DECREASING	10.3%	Lower	-	-	2003 US data are preliminary.
121	Vital Stats	BRTHS			Birth rate to adolescent females, per 1,000										
122	Vital Stats	BRTHS			a. Age 10-14		0.4	2003	-	-	0.67	Lower	-	-	2003 US data are preliminary.
123	Vital Stats	BRTHS			b. Age 15-19		36.2	2003	-	DECREASING	42.2	Lower	43	Lower	2003 US data are preliminary.
124	Vital Stats	BRTHS			Repeat births to adolescent females, per 1,000										
125	Vital Stats	BRTHS			a. Age 10-14		0.0	2003	-	-	0.01	N.S.D.	-	-	Actual Nebraska number is 0. 2003 US data are preliminary.
126	Vital Stats	BRTHS			b. Age 15-19		6.7	2003	-	N.L.C.	8.4	Lower	-	-	2003 US data are preliminary.
127	RISK BEHAVIORS														
128	YRBS	Risk B'havr			Ever had sexual intercourse		42.8%	2003	-	-	46.7%	Lower	-	-	
129	YRBS	Mntal Health			Boys		43.7%	2003	-	-	-	-	-	-	
130	YRBS	Mntal Health			Girls		42.0%	2003	-	-	-	-	-	-	
131	YRBS	Risk B'havr			Had sexual intercourse with 1 or more persons during the past 3 months		31.5%	2003	-	-	14.4%	Higher	-	-	Response for "Had sex with 4 or more in life time."
132	YRBS	Mntal Health			Boys		30.1%	2003	-	-	-	-	-	-	
133	YRBS	Mntal Health			Girls		32.9%	2003	-	-	-	-	-	-	
134	YRBS	Risk B'havr			Sexual intercourse in past 3 mths & reported alcohol and drug use the last sexual intercourse		30.5%	2003	-	-	25.4%	Higher	-	-	
135	YRBS	Mntal Health			Boys		35.2%	2003	-	-	-	-	-	-	
136	YRBS	Mntal Health			Girls		26.1%	2003	-	-	-	-	-	-	
137	YRBS	Risk B'havr			Sexual intercourse in past 3 mths & used a condom the last time of sexual intercourse		60.2%	2003	-	-	63.0%	Lower	-	-	HP Target for ages 15-17.
138	YRBS	Mntal Health			Boys		65.2%	2003	-	-	-	-	49%	Higher	
139	YRBS	Mntal Health			Girls		55.8%	2003	-	-	-	-	79%	Lower	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
															HP F-11%, M-20%, ages 15-17, Obj. reads condom and hormonal method used"
140	YRBS	Risk B'havr				Sexual intercourse in the past 3 mths & used birth control pills during the last sexual intercourse	21.9%	2003	-	-	17.0%	Higher		-	
141	YRBS	Mntal Health				Boys	13.8%	2003	-	-	-	-	11%	Higher	
142	YRBS	Mntal Health				Girls	29.3%	2003	-	-	-	-	20%	Higher	
															HP2010 objective is for "rape or attempted rape"
143	YRBS	Injury				Ever physically forced to have sexual intercourse when they did not want to.	9.9%	2003	-	-	9.0%	Higher	7%	Higher	
144	YRBS	Mntal Health				Boys	8.3%	2003	-	-	-	-	-	-	
145	YRBS	Mntal Health				Girls	11.7%	2003	-	-	-	-	-	-	
146	YRBS	Injury				Ever hit, slapped or physically hurt on purpose by girl/boy friend.	11.5%	2003	-	-	-	-	-	-	
147	YRBS	Mntal Health				Boys	11.0%	2003	-	-	-	-	-	-	
148	YRBS	Mntal Health				Girls	12.0%	2003	-	-	-	-	-	-	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
															HP20 10 objec tive is for grade s 9- 12; "carri ed weap on on scho ol prope rty"
149	YRBS	Injury	Carried a weapon (gun, knife, club) on 1 or more of the past 30 days				16.0%	2003	-	-	17.1%	Lower	4.9%	Higher	
150	YRBS	Mntal Health	Boys				27.0%	2003	-	-	-	-	-	-	
151	YRBS	Mntal Health	Girls				4.7%	2003	-	-	-	-	-	-	
152	YRBS	Injury	Not attend school because felt unsafe at school or to/from school in the the past 30 days				3.1%	2003	-	-	5.4%	Lower	-	-	
153	YRBS	Mntal Health	Boys				3.1%	2003	-	-	-	-	-	-	
154	YRBS	Mntal Health	Girls				3.2%	2003	-	-	-	-	-	-	
155	YRBS	Injury	Threatened or injured with a weapon on school property one or more times in past yr.				8.8%	2003	-	-	9.2%	N.S.D.	-	-	
156	YRBS	Mntal Health	Boys				12.0%	2003	-	-	-	-	-	-	
157	YRBS	Mntal Health	Girls				5.5%	2003	-	-	-	-	-	-	
															HP20 10 objec tive is for grade s 9- 12
158	YRBS	Injury	In a physical fight 1 or more time in last 12 months.				29.6%	2003	-	-	33%	Lower	32%	Lower	
159	YRBS	Mntal Health	Boys				37.8%	2003	-	-	-	-	-	-	
160	YRBS	Mntal Health	Girls				21.0%	2003	-	-	-	-	-	-	
161	YRBS	Injury	Drove a car after drinking alcohol in past 30 days				20.9%	2003	-	-	12.1%	Higher	-	-	
162	YRBS	Mntal Health	Boys				22.1%	2003	-	-	-	-	-	-	
163	YRBS	Mntal Health	Girls				19.6%	2003	-	-	-	-	-	-	
															HP20 10 objec tive is for grade s 9- 12
164	YRBS	Risk B'havr/ Injury	Rode with a driver who had been drinking alcohol during the past 30 days.				38.5%	2003	-	-	30%	Higher	30%	Higher	
165	YRBS	Mntal Health	Boys				39.9%	2003	-	-	-	-	-	-	
166	YRBS	Mntal Health	Girls				37.7%	2003	-	-	-	-	-	-	
											18.2%				HP20 10 objec tive is for grade s 9- 12; "seat belt use"
167	YRBS	Injury	Never or rarely use passenger restraints when riding in car driven by someone else				21.9%	2003	-	-	-	Higher	8%	Higher	
168	YRBS	Mntal Health	Boys				28.1%	2003	-	-	-	-	-	-	
169	YRBS	Mntal Health	Girls				15.3%	2003	-	-	-	-	-	-	
170	SUBSTANCE USE & EXPOSURE														
															US data from Leg acy Foun dati on Repo rt, 2001. HP20 10 objec tive is for childr en under 10.
171	Tobacco Survey	Smok Expo	Current household exposure to tobacco smoke, households with children 13-17				23.6%		-	-	22.0%	N.S.D.	10%	Higher	
172	Tobacco Survey	Smok Expo	Percentage of children 5-12 years old exposed to tobacco smoke				28.0%		-	-	-	-	-	-	
173	Tobacco Survey	Smok Expo	Percentage of children 13-17 years old exposed to tobacco smoke				33.2%		-	-	-	-	-	-	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
174 YRBS		Risk B'havr				Smoked cigarettes, used smokeless tobacco, or smoked cigars during the past 30 days.	30.8%	2003	-	-	27%	Higher	21%	Higher	US Data for 2003, HP20 10 objective for grades 9-12
175 YRBS		Mntal Health				Boys	33.5%	2003	-	-	-	-	-	-	
176 YRBS		Mntal Health				Girls	28.0%	2003	-	-	-	-	-	-	
177 YRBS		Risk B'havr				Smoked cigarettes during the past 30 days.	24.1%	2003	-	-	22%	Higher	16%	Higher	YRB S data for 2003, HP20 10 objective for grades 9-12
178 YRBS		Mntal Health				Boys	22.5%	2003	-	-	-	-	-	-	
179 YRBS		Mntal Health				Girls	25.8%	2003	-	-	-	-	-	-	
180 EPSDT		Risk B'havr				Current household exposure to alcohol or substance abuse	data not available		-	-	63.9%	-	45%	-	US data for 1999-2000, HP20 10 objective for ages 12-17
181 YRBS		Risk B'havr				Had at least one drink of alcohol on one or more of the last 30 days.	46.5%	2003	-	-	44.9%	Higher	-	-	
182 YRBS		Mntal Health				Boys	43.8%	2003	-	-	-	-	-	-	
183 YRBS		Mntal Health				Girls	49.3%	2003	-	-	-	-	-	-	
184 YRBS		Risk B'havr				Had 5 + drinks of alcohol in a row in 1 sitting on one or more of the past 30 days.	32.2%	2003	-	-	28.3%	Higher	11%	Higher	HP20 10 objective listed for grade 12 only; objective for ages 12-17 is 2.0%
185 YRBS		Mntal Health				Boys	32.6%	2003	-	-	-	-	-	-	
186 YRBS		Mntal Health				Girls	31.6%	2003	-	-	-	-	-	-	
187 YRBS		Risk B'havr				Used illegal drugs one or more times during their life	38.4%	2003	-	-	-	-	-	-	
188 YRBS		Mntal Health				Boys	39.9%	2003	-	-	-	-	-	-	
189 YRBS		Mntal Health				Girls	37.0%	2003	-	-	-	-	-	-	
190 YRBS		Risk B'havr				Marijuana use in the past 30 days	18.3%	2003	-	-	22.4%	Lower	0.7%	Higher	HP20 10 objective is for ages 12-17
191 YRBS		Mntal Health				Boys	20.5%	2003	-	-	-	-	-	-	
192 YRBS		Mntal Health				Girls	16.0%	2003	-	-	-	-	-	-	
193 YRBS		Risk B'havr				Cocaine use in the past 30 days	2.9%	2003	-	-	4.1%	Lower	-	-	HP20 10 objective is for ages 12-17
194 YRBS		Mntal Health				Boys	3.3%	2003	-	-	-	-	-	-	
195 YRBS		Mntal Health				Girls	2.4%	2003	-	-	-	-	-	-	

	A	B	C	E	F	G	J	K	L	M	N	O	P	Q	R
															HP20 10 objec tive is for ages 12- 17
196	YRBS	Risk B'havr	Inhalant use in past 30 days				3.9%	2003	-	-	3.9%	N.S.D.	0.7%	Higher	
197	YRBS	Mntal Health	Boys				4.4%	2003	-	-	-	-	-	-	
198	YRBS	Mntal Health	Girls				3.4%	2003	-	-	-	-	-	-	
199	YRBS	Risk B'havr	Methamphetamine use one or more times in their life				6.3%	2003	-	-	7.6%	Lower	-	-	
200	YRBS	Mntal Health	Boys				5.8%	2003	-	-	-	-	-	-	
201	YRBS	Mntal Health	Girls				6.9%	2003	-	-	-	-	-	-	
202	YRBS	Risk B'havr	Ecstasy use one or more times in their life				5.0%	2003	-	-	11.1%	Lower	-	-	
203	YRBS	Mntal Health	Boys				5.6%	2003	-	-	-	-	-	-	
204	YRBS	Mntal Health	Girls				4.3%	2003	-	-	-	-	-	-	
															HP20 10 objec tive is for grade 12, 8th and 10th grade data (natio nal) and objec tives also avala ble
205	YRBS	Risk B'havr	Illegal steroid use one or more times in their life				3.6%	2003	-	-	6.1%	Lower	0.4%	Higher	
206	YRBS	Mntal Health	Boys				4.3%	2003	-	-	-	-	-	-	
207	YRBS	Mntal Health	Girls				2.9%	2003	-	-	-	-	-	-	